Montana Legislative History

Chapter: 416 Session L: 2005

Bill Number: 481 Senate

Checklist of Bill History

History and Final Status Sheet	x
Introduced Bill	X
Fiscal Note	N/A
Third Reading Bill	X
Final Version of Bill	X

House

Committee:
Human Services

Hearing Date(s):
March 23, 2005
April 1, 2005
(Executive Action)

Senate

Committee:
Business, Labor, and Economic Affairs

Hearing Date(s):
Feb. 17, 2005*

Feb. 19, 2005 (Executive Action)

* The minutes indicated that this was heard on Feb. 14, 2005, but the link to those minutes is not available

Conference Committee

Hearing Date(s): n/a

Conference Committee Report:

Compiler Notes

Compiled by: sg

Date: 3/25/2024

Notes: The links to the audio minutes do not work.

Bill Draft Number: LC0255
Bill Type - Number: SB 481
Short Title: Merge occupational diseases into Workers' Compensation Act
Primary Sponsor: Vicki Cocchiarella (D) SD 47
Chapter Number: 416

Bill Actions - **Current Bill Progress:** Became Law

Bill Action Count: 55

Action - Most Recent First	Date	Votes Yes	Votes No	Committee
Chapter Number Assigned	04/26/2005			
(S) Signed by Governor	04/25/2005			
(S) Transmitted to Governor	04/16/2005			
(H) Signed by Speaker	04/14/2005			
(S) Signed by President	04/14/2005			
(C) Printed - New Version Available	04/13/2005			
(S) Returned from Enrolling	04/12/2005			
(S) Sent to Enrolling	04/11/2005			
(S) 3rd Reading Passed as Amended by House	04/09/2005	47	3	
(S) Scheduled for 3rd Reading	04/09/2005			
(S) 2nd Reading House Amendments Concurred on Voice Vote	04/08/2005	49	1	
(S) Scheduled for 2nd Reading	04/08/2005			
(H) Returned to Senate with Amendments	04/06/2005			
(H) 3rd Reading Concurred	04/06/2005	93	7	
(H) Scheduled for 3rd Reading	04/06/2005			
(H) 2nd Reading Concurred	04/05/2005	96	3	
(H) Scheduled for 2nd Reading	04/05/2005			
(C) Printed - New Version Available	04/02/2005			
(H) Committee Report--Bill Concurred as Amended	04/02/2005			(H) Human Services
(H) Committee Executive Action--Bill Concurred as Amended	04/02/2005	16	0	(H) Human Services
(H) Hearing	03/23/2005			(H) Human Services
(H) Rereferred to Committee	03/17/2005			(H) Human Services
(H) Referred to Committee	03/07/2005			(H) Business and Labor
(H) First Reading	03/07/2005			
(S) Transmitted to House	02/22/2005			
(S) 3rd Reading Passed	02/22/2005	50	0	
(S) Scheduled for 3rd Reading	02/22/2005			
(S) 2nd Reading Passed on Voice Vote	02/21/2005	50	0	
(S) 2nd Reading Motion to Amend Failed	02/21/2005	23	26	

(S) Scheduled for 2nd Reading	02/21/2005			
(S) Fiscal Note Printed	02/19/2005			
(S) Committee Report--Bill Passed as Amended	02/19/2005			(S) Business, Labor, and Economic Affairs
(S) Committee Executive Action--Bill Passed as Amended	02/19/2005	11	0	(S) Business, Labor, and Economic Affairs
(C) Printed - New Version Available	02/19/2005			
(S) Fiscal Note Signed	02/18/2005			
(S) Fiscal Note Received	02/18/2005			
(S) Hearing	02/17/2005			(S) Business, Labor, and Economic Affairs
(C) Introduced Bill Text Available Electronically	02/14/2005			
(S) Fiscal Note Requested	02/14/2005			
(S) Referred to Committee	02/14/2005			(S) Business, Labor, and Economic Affairs
(S) First Reading	02/14/2005			
(S) Introduced	02/14/2005			
(C) Draft Delivered to Requester	02/14/2005			
(C) Draft Ready for Delivery	02/12/2005			
(C) Draft in Assembly/Executive Director Review	02/12/2005			
(C) Draft in Final Drafter Review	02/11/2005			
(C) Draft in Input/Proofing	02/11/2005			
(C) Bill Draft Text Available Electronically	02/11/2005			
(C) Draft to Drafter - Edit Review [JLN]	02/10/2005			
(C) Draft in Edit	02/10/2005			
(C) Draft in Legal Review	02/10/2005			
(C) Draft to Requester for Review	02/10/2005			
(C) Draft Taken Off Hold	02/04/2005			
(C) Draft On Hold	08/18/2004			
(C) Draft Request Received	08/10/2004			

Sponsor, etc.

Sponsor, etc.	Last Name/Organization	First Name	Mi
Requester	Cocchiarella	Vicki	
Drafter	McClure	Eddye	
Primary Sponsor	Cocchiarella	Vicki	

Subjects

Description	Revenue/Approp.	Vote Majority Req.	Subject Code

Workers' Compensation (see also: Labor and Employment)	Simple	WORK

Additional Bill Information

Fiscal Note Probable: Yes
Preintroduction Required: N
Session Law Ch. Number: 416
DEADLINE
Category: General Bills
Transmittal Date: 03/01/2005
Return (with 2nd house amendments) Date: 04/06/2005

Section Effective Dates

Section(s)	Effective Date	Date Qualified
All Sections	01-JUL-05	

MINUTES

MONTANA SENATE
59th LEGISLATURE - REGULAR SESSION

COMMITTEE ON BUSINESS, LABOR, AND ECONOMIC AFFAIRS

Call to Order: By **CHAIRMAN VICKI COCCHIARELLA**, on February 17, 2005 at 7:30 A.M., in Room 422 Capitol.

ROLL CALL

Members Present:

Sen. Vicki Cocchiarella, Chairman (D)
Sen. Joe Balyeat (R)
Sen. Duane Grimes (R)
Sen. Dave Lewis (R)
Sen. Glenn Roush (D)
Sen. Frank Smith (D)
Sen. Carolyn Squires (D)
Sen. Donald J. Steinbeisser (R)
Sen. Bill Tash (R)
Sen. Joseph (Joe) Tropila (D)

Members Excused:

Sen. Jon Tester (D)

Members Absent: None.

Staff Present: Annie Glover, Committee Secretary
Pat Murdo, Legislative Branch

Audio Committees: These minutes are in outline form only. They provide a list of participants and a record of official action taken by the committee. The link to the audio recording of the meeting is available on the Legislative Branch website.

Committee Business Summary:

Hearing & Date Posted:	SB 481, 2/14/2005; SB 12, 2/14/2005; SB 466, 2/14/2005; SB 434, 2/14/2005; SB 444, 2/14/2005
Executive Action:	SB 412, SB 439, SB 388, SB 466, SB 434, SB 349, SB 12

00:00:00

EXECUTIVE ACTION ON SB 412

Motion: SEN. SQUIRES moved that SB 412 DO PASS.

Discussion:

Motion: SEN. COCCHIARELLA moved that SB 412 BE AMENDED WITH SB041201.APM.

Discussion:

EXHIBIT(bus39a01)

Vote: Motion carried unanimously by voice vote.

Motion: SEN. SQUIRES moved that SB 412 DO PASS AS AMENDED.

Discussion:

Vote: Motion carried 9-2 by roll call vote with SEN. BALYEAT and SEN. STEINBEISSER voting no.
SEN. COCCHIARELLA proxied for **SEN. TESTER.**

00:06:39

EXECUTIVE ACTION ON SB 439

Motion: SEN. GRIMES moved that SB 439 DO PASS.

Motion: SEN. GRIMES moved that SB 439 BE AMENDED WITH SB043901.APM.

Discussion:

EXHIBIT(bus39a02)

Vote: Motion carried unanimously by voice vote.

Motion: SEN. GRIMES moved that SB 439 DO PASS AS AMENDED.

Discussion:

Vote: Motion carried 6-5 with SEN. BALYEAT, SEN. GRIMES, SEN. LEWIS, SEN. STEINBEISSER, and SEN. TASH voting no.
SEN. COCCHIARELLA proxied for **SEN. TESTER.**

00:11:52

EXECUTIVE ACTION ON SB 388

Motion: SEN. TROPILA moved that SB 388 DO PASS.

Discussion:

Motion: SEN. GRIMES moved that SB 388 BE AMENDED WITH SB038801.APM 2,4,5.

Discussion:

EXHIBIT(bus39a03)

Vote: Motion carried unanimously by voice vote.

Motion: SEN. LEWIS moved that SB 388 BE AMENDED WITH SB038801.APM 1,3.

Discussion:

Vote: Motion carried unanimously by voice vote.

Motion: SEN. ROUSH moved that SB 388 BE AMENDED WITH SB038802.APM.

EXHIBIT(bus39a04)

Vote: Motion carried 9-2 by voice vote with SEN. BALYEAT and SEN. GRIMES voting no.

Motion: SEN. TROPILA moved SB 388 BE AMENDED WITH SB038803.APM.

Discussion:

EXHIBIT(bus39a05)

Vote: Motion carried unanimously by voice vote.

Motion: SEN. TROPILA moved that SB 388 DO PASS AS AMENDED.

Discussion:

Vote: Motion carried 9-2 by voice vote with SEN. BALYEAT and SEN. STEINBEISSER voting no.
SEN. COCCHIARELLA proxied for **SEN. TESTER.**
SEN. LEWIS proxied for **SEN. BALYEAT.**

00:36:41

DUAL HEARING ON SB 481 AND SB 12

Opening Statement by Sponsors:

SEN. VICKI COCCHIARELLA (D), SD 47, opened the hearing on **SB 481,** Merge occupational diseases into Workers' Compensation Act.

SEN. JEFF MANGAN (D), SD 12, opened the hearing on **SB 12,** Revise occupational disease law to reflect court decisions.

Proponents' Testimony:

00:48:43 **Ms. Nancy Butler, Montana State Fund**
00:52:14 **Mr. George Wood, Montana Self Insurers Association**
00:52:56 **Ms. Jacqueline Lenmark, American Insurance Association, and on behalf of Mr. Larry Jones, Liberty Northwest**
00:55:05 **Mr. Jed Fitch, Montana Trial Lawyers Association**

EXHIBIT(bus39a06)

01:00:09 **Mr. Bob Worthington, Montana Municipal Insurance Authority**
01:00:54 **Mr. Dick Martin, Attorney**
01:05:44 **Mr. Shawn Bubb, Director of Insurance Services, Montana School Board System**

Opponents' Testimony: None.

Informational Testimony:

01:10:18 **Ms. Diana Ferriter, Department of Labor and Industry**

EXHIBIT(bus39a07)
EXHIBIT(bus39a08)

01:14:40
Questions from Committee Members and Responses:

01:32:42
Closing by Sponsors:

01:35:40

HEARING ON SB 466

Opening Statement by Sponsor:

SEN. JOHN ESP (R), SD 31, opened the hearing on **SB 466,** Revise mortgage and deed of trust laws.

Proponents' Testimony:

01:39:58 **Mr. Robert Sewell, Montana Land Title Association**
01:44:18 **Mr. Glenn Oppel, Montana Association of Realtors**

EXHIBIT(bus39a09)

01:45:20 **Ms. Leanne Fenske, Montana Land Title Association**

Opponents' Testimony: None.

Informational Testimony: None.

Questions from Committee Members and Responses: None.

01:49:18
Closing by Sponsor:

01:49:51

HEARING ON SB 434

Opening Statement by Sponsor:

SEN. DAVE LEWIS (R), SD 42, opened the hearing on **SB 434,** Revise insurance form filing and approval law.

Proponents' Testimony:

01:51:56 **Mr. Frank Cote, America's Health Insurance Plans, Blue Cross, Blue Shield**
01:53:20 **Mr. James Senterfitt, New West Health Services**
01:54:00 **Ms. Jacqueline Lenmark, American Insurance Association, American Council of Life Insurers**
01:54:24 **Ms. Alicia Pichette, State Auditor's Office**

EXHIBIT(bus39a10)

Opponents' Testimony: None.

Informational Testimony: None.

Questions from Committee Members and Responses: None.

01:55:46
Closing by Sponsor:

01:55:57

EXECUTIVE ACTION ON SB 466

Motion/Vote: **SEN. GRIMES moved that SB 466 DO PASS. Motion carried unanimously by voice vote.**
SEN. COCCHIARELLA proxied for **SEN. TESTER.**

01:57:23

EXECUTIVE ACTION ON SB 434

Motion/Vote: **SEN. TROPILA moved that SB 434 DO PASS. Motion carried unanimously by voice vote.**
SEN. COCCHIARELLA proxied for **SEN. TESTER.**

01:58:47

HEARING ON SB 444

Opening Statement by Sponsor:

SEN. FRANK SMITH (D), SD 16, opened the hearing on **SB 444,** Revise purchase of military service in certain public retirement systems.

Proponents' Testimony:

02:02:46 **Mr. Roger Hagan, Montana Air and Army National Guard**
02:08:57 **Mr. Pat Clinch, Montana State Council of Professional Firefighters**

Opponents' Testimony:

02:10:20 **Mr. Kelly Jenkins, Public Employees Retirement Board**

EXHIBIT(bus39a11)
EXHIBIT(bus39a12)

Informational Testimony: None.

02:20:48
Questions from Committee Members and Responses:

02:35:35
Closing by Sponsor:

02:37:32

EXECUTIVE ACTION ON SB 349

Motion: SEN. GRIMES moved that SB 349 DO PASS.

Motion: SEN. COCCHIARELLA moved that SB 349 BE AMENDED WITH SB034901.APM.

Discussion:

EXHIBIT(bus39a13)

Ms. Jacqueline Lenmark, American Insurance Assocation

Vote: Motion carried unanimously by voice vote.

Motion: SEN. ROUSH moved that SB 349 DO PASS AS AMENDED.

Discussion:

Vote: Motion carried unanimously by voice vote.
SEN. COCCHIARELLA proxied for **SEN. TESTER.**

02:50:06

EXECUTIVE ACTION ON SB 12

Motion/Vote: SEN. SQUIRES moved that SB 12 BE TABLED. Motion carried 10-1 by voice vote with SEN. TROPILA voting no.
SEN. COCCHIARELLA proxied for **SEN. TESTER.**

02:56:28

DISCUSSION ON SB 311

Discussion:

Ms. Jacqueline Lenmark, American Insurance Association

EXHIBIT(bus39a14)

ADJOURNMENT

Adjournment: 11:00 A.M.

_____
SEN. VICKI COCCHIARELLA, Chairman

_____
ANNIE GLOVER, Secretary

VC/ag

Additional Exhibits:

EXHIBIT(bus39aad0.PDF)

MINUTES

MONTANA SENATE
59th LEGISLATURE - REGULAR SESSION

COMMITTEE ON BUSINESS, LABOR, AND ECONOMIC AFFAIRS

Call to Order: By **CHAIRMAN VICKI COCCHIARELLA**, on February 18, 2005 at 8:00 A.M., in Room 422 Capitol.

ROLL CALL

Members Present:
Sen. Vicki Cocchiarella, Chairman (D)
Sen. Joe Balyeat (R)
Sen. Duane Grimes (R)
Sen. Dave Lewis (R)
Sen. Glenn Roush (D)
Sen. Frank Smith (D)
Sen. Carolyn Squires (D)
Sen. Donald J. Steinbeisser (R)
Sen. Bill Tash (R)
Sen. Joseph (Joe) Tropila (D)

Members Excused:
Sen. Jon Tester (D)

Members Absent: None.

Staff Present: Annie Glover, Committee Secretary
Pat Murdo, Legislative Branch

Audio Committees: These minutes are in outline form only. They provide a list of participants and a record of official action taken by the committee. The link to the audio recording of the meeting is available on the Legislative Branch website.

Committee Business Summary:

Hearing & Date Posted:	SB 424, 2/15/2005; SB 425, 2/15/2005; SB 451, 2/15/2005; SB 454, 2/15/2005; SB 457, 2/15/2005; SB 443, 2/15/2005
Executive Action:	SB 443, SB 454, SB 451, SB 424, SB 425, SB 388, SB 114, SB 380, SB 481, SB 311

00:00:01

DUAL HEARING ON SB 424 AND SB 425

Opening Statement by Sponsor:

SEN. COREY STAPLETON (R), SD 27, opened the hearing on **SB 424,** Transfer state financial institution functions to state auditor.

SEN. COREY STAPLETON (R), SD 27, opened the hearing on **SB 425,** Change name of state auditor to commissioner of financial services.

EXHIBIT(bus40a01)

Proponents' Testimony:

00:06:56 **Mr. John Morrison, State Auditor, Commissioner of Insurance**

Opponents' Testimony:

00:14:23 **Mr. Keith Colbo, Executive Director, Montana Independent Bankers**
00:17:25 **Mr. Steve Turkiewicz, President, Montana Banker's Association**
00:20:32 **Mr. Russ Ritter, Executive, Washington Corporation, Former board member, Wells Fargo, Former Mayor, Helena, State Banking Board**

EXHIBIT(bus40a02)

00:28:28 **Ms. Tracie Kenyon, President, Montana Credit Union Network**

EXHIBIT(bus40a03)

Informational Testimony:

00:29:47 **Ms. Annie Goodwin, Commissioner of Banking and Financial Institutions**

EXHIBIT(bus40a04)
EXHIBIT(bus40a05)

00:30:15
Questions from Committee Members and Responses:

00:37:28
Closing by Sponsor:

00:41:43 Break.
00:43:39 Resume.

00:43:51

HEARING ON SB 451

Opening Statement by Sponsor:

SEN. MIKE WHEAT (D), SD 32, opened the hearing on **SB 451,** Revise speech-language and audiologists licensing laws.

EXHIBIT(bus40a06)

Proponents' Testimony:

00:45:21 **Mr. Darrell Micken, Audiologist, Speech Pathology and Audiology Licensure Board**
00:55:08 **Ms. Laura Jo McKamey, President, Montana Speech and Hearing Association**
00:58:44 **Ms. Nanette Smith, Montana Speech and Hearing Association**

Opponents' Testimony:

01:00:04 **Dr. Scott Pargot, Ear, Nose and Throat Physician, Montana Association of Otolaryngologists**
01:01:18 **Mr. Pat Melby, Montana Medical Association**
01:01:57 **Ms. Laura Hermenson, Montana Society of Otolaryngology**

Informational Testimony:

01:02:35 **Ms. Marilyn Kelly-Clark, Department of Labor and Industry**

01:03:18
Questions from Committee Members and Responses:

01:03:51
Closing by Sponsor:

01:04:29 Break.
01:07:14 Resume.

01:07:26

HEARING ON SB 454

Opening Statement by Sponsor:

SEN. KELLY GEBHARDT (R), SD 23, opened the hearing on **SB 454,** Revise requirements for add-on basis consumer loan.

Proponents' Testimony:

01:08:34 **Mr. Jerry Loendorf, Montana Consumer Finance Association**
01:19:03 **Ms. Mona Jamison, Wells Fargo Financial**
01:25:43 **Mr. Mark Staples, Citi Financial**

Opponents' Testimony: None.

Informational Testimony:

01:27:55 **Ms. Annie Goodwin, Commissioner of Banking and Financial Institutions**

01:28:30
Questions from Committee Members and Responses:

01:35:32
Closing by Sponsor:

01:36:10

HEARING ON SB 457

Opening Statement by Sponsor:

SEN. KELLY GEBHARDT (R), SD 23, opened the hearing on **SB 457,** Clarify requirements for cancellation of insurance for nonpayment of premiums.

EXHIBIT(bus40a07)

Proponents' Testimony:

01:37:49 **Mr. Roger McGlenn, Executive Director, Independent Insurance Agents of Montana**
01:41:47 **Mr. Larry Kibbee, Property Casualty Insurers Association of America**

Opponents' Testimony:

01:45:33 **Ms. Alicia Pichette, State Auditor's Office**

EXHIBIT(bus40a08)

Informational Testimony: None.

01:47:24
Questions from Committee Members and Responses:

02:00:33
Closing by Sponsor:

02:02:39

HEARING ON SB 443

Opening Statement by Sponsor:

SEN. GLENN ROUSH (D), SD 8, opened the hearing on **SB 443**, Auto insurance premium reductions for certain national guard members.

Proponents' Testimony:

02:05:49 **Mr. Roger Hagan, Officer and Enlisted Associations of the Montana National Guard**

EXHIBIT(bus40a09)
EXHIBIT(bus40a10)
EXHIBIT(bus40a11)
EXHIBIT(bus40a12)

Opponents' Testimony:

02:09:55 **Mr. Jon Metropoulos, Farmer's Insurance Group, and on behalf of Mr. Greg Van Horssen, State Farm, and Ms. Jacqueline Lenmark, American Insurance Association**

Informational Testimony: None.

02:11:03
Questions from Committee Members and Responses:

02:15:20
Closing by Sponsor:

02:16:48 Break.
02:36:35 Resume.

02:36:55

EXECUTIVE ACTION ON SB 443

Motion: SEN. ROUSH moved that SB 443 DO PASS.

Discussion:

Vote: Motion carried 10-1 by voice vote with SEN. STEINBEISSER voting no.
SEN. COCCHIARELLA proxied for **SEN. TESTER.**
SEN. LEWIS proxied for **SEN. BALYEAT.**

02:38:24

EXECUTIVE ACTION ON SB 454

Motion: SEN. LEWIS moved that SB 454 DO PASS.

Motion/Vote: SEN. LEWIS moved that SB 454 BE AMENDED CONCEPTUALLY. Motion carried unanimously by voice vote.

Motion: SEN. LEWIS moved that SB 454 DO PASS AS AMENDED.

Discussion:

Vote: Motion carried unanimously by voice vote.
SEN. COCCHIARELLA proxied for **SEN. TESTER.**
SEN. LEWIS proxied for **SEN. BALYEAT.**

02:41:24

EXECUTIVE ACTION ON SB 451

Motion: SEN. SQUIRES moved that SB 451 DO PASS.

Motion: SEN. SQUIRES moved that SB 451 BE AMENDED CONCEPTUALLY.

Discussion:

Vote: Motion carried unanimously by voice vote.

Motion/Vote: SEN. SQUIRES moved that SB 451 DO PASS AS AMENDED. Motion carried unanimously by voice vote.
SEN. COCCHIARELLA proxied for **SEN. TESTER.**
SEN. LEWIS proxied for **SEN. BALYEAT.**

02:43:02

EXECUTIVE ACTION ON SB 424

Motion/Vote: SEN. LEWIS moved that SB 424 BE TABLED. Motion carried unanimously by voice vote.
SEN. COCCHIARELLA proxied for **SEN. TESTER.**
SEN. LEWIS proxied for **SEN. BALYEAT.**

02:43:48

EXECUTIVE ACTION ON SB 425

Motion/Vote: SEN. LEWIS moved that SB 425 BE TABLED. Motion carried unanimously by voice vote.
SEN. COCCHIARELLA proxied for **SEN. TESTER.**
SEN. LEWIS proxied for **SEN. BALYEAT.**

02:44:40

EXECUTIVE ACTION ON SB 388

Motion: SEN. TROPILA moved RECONSIDER THE MOTION on SB 388.

EXHIBIT(bus40a13)

Vote: Motion carried unanimously by voice vote.

Motion: SEN. ROUSH moved that SB 388 DO PASS.

Motion: SEN. ROUSH moved that SB 388 BE AMENDED WITH SB038805.APM.

Discussion:

Vote: Motion carried unanimously by voice vote.

Motion/Vote: SEN. ROUSH moved that SB 388 DO PASS AS AMENDED. Motion carried 9-2 by voice vote with SEN. BALYEAT and SEN. STEINBEISSER voting no.
SEN. COCCHIARELLA proxied for **SEN. TESTER.**
SEN. LEWIS proxied for **SEN. BALYEAT.**

02:48:54

EXECUTIVE ACTION ON SB 114

Motion: SEN. ROUSH moved that SB 114 DO PASS.

Discussion:

Ms. Christina Goe, State Auditor's Office
Ms. Jacqueline Lenmark, American Insurance Association

Motion: SEN. SQUIRES moved that SB 114 BE AMENDED WITH SB011401.APM.

Discussion:

EXHIBIT(bus40a14)

Vote: Motion carried unanimously by voice vote.

Motion: SEN. GRIMES moved that SB 114 DO PASS AS AMENDED.

Discussion:

Ms. Christina Goe, State Auditor's Office

Vote: Motion carried 9-2 by voice vote with SEN. BALYEAT and SEN. GRIMES voting no.
SEN. COCCHIARELLA proxied for **SEN. TESTER.**
SEN. LEWIS proxied for **SEN. BALYEAT.**

03:01:54

EXECUTIVE ACTION ON SB 380

Motion: SEN. SQUIRES moved that SB 380 DO PASS.

Motion: SEN. SQUIRES moved that SB 380 BE AMENDED WITH SB0380003.APM.

Discussion:

EXHIBIT(bus40a15)

Vote: Motion carried unanimously by voice vote.
SEN. LEWIS proxied for **SEN. BALYEAT.**

Motion: SEN. SQUIRES moved that SB 380 BE AMENDED WITH SB038001.APM.

Discussion:

EXHIBIT(bus40a16)

Ms. Christina Goe, State Auditor's Office

03:13:47 **SEN. BALYEAT ENTERED**

Vote: Motion carried unanimously by voice vote.

Motion: SEN. SQUIRES moved that SB 380 DO PASS AS AMENDED.

Discussion:

Vote: Motion carried unanimously by voice vote.
SEN. COCCHIARELLA proxied for **SEN. TESTER.**

03:17:16

EXECUTIVE ACTION ON SB 481

Motion: SEN. ROUSH moved that SB 481 DO PASS.

Motion: SEN. COCCHIARELLA moved that SB 481 BE AMENDED WITH SB048101.AEM.
SEN. COCCHIARELLA proxied for **SEN. TESTER.**

Discussion:

EXHIBIT(bus40a17)

Ms. Nancy Butler, Montana State Fund

Vote: Motion carried unanimously by voice vote.

Motion: SEN. ROUSH moved that SB 481 DO PASS AS AMENDED.

Discussion:

Vote: Motion carried unanimously by voice vote.

03:27:21

EXECUTIVE ACTION ON SB 311

Motion: SEN. SMITH moved that SB 311 DO PASS.

Discussion:

Motion: SEN. SMITH moved that SB 311 BE AMENDED WITH SB031102.APM.

Discussion:

EXHIBIT(bus40a18)

Ms. Alicia Pichette, State Auditor's Office
Ms. Jacqueline Lenmark, American Insurance Association

Motion: **SEN. COCCHIARELLA made a SUBSTITUTE MOTION that SB 311 BE AMENDED BY SEGREGATING 9D, 10, 11, 12, 13G OUT OF SB031102.APM WHILE MAINTAINING THE REMAINDER OF THE AMENDMENT.**

Discussion:

Ms. Alicia Pichette, State Auditor's Office
Ms. Jacqueline Lenmark, American Insurance Association

EXHIBIT(bus40a19)

Note: Action was postponed until a February 19, 2005.

ADJOURNMENT

Adjournment: 12:00 P.M.

_____
SEN. VICKI COCCHIARELLA, Chairman

_____
ANNIE GLOVER, Secretary

VC/ag

Additional Exhibits:

EXHIBIT(bus40aad0.PDF)

SENATE BUSINESS & INDUSTRY 7
EXHIBIT NO. 17
DATE 2/18/05
BILL NO. SB481

Amendments to Senate Bill No. 481
1st Reading Copy

Requested by Senator Vicki Cocchiarella

For the Senate Business, Labor, and Economic Affairs Committee

Prepared by Eddye McClure
February 18, 2005 (7:16am)

1. Page 1, lines 27 through 30.
Following: "(2)" on line 27
Strike: remainder of line 27 through "injury" on line 30
Insert: "When the same medical condition may be claimed as an injury and an occupational disease, compensation payable to the claimant, the claimant's beneficiaries, or the claimant's dependents may not be duplicated for the same conditions over the same time period"

2. Page 6, line 24.
Following: "known"
Strike: "of exposure to"
Insert: "that the worker's condition resulted from"

3. Page 37, line 27.
Following: line 26
Insert: "NEW SECTION. **Section 40. Coordination instruction.** If House Bill No. 126 is passed and approved and if it includes a section that repeals 39-71-416, then [section 21 of this act], amending 39-71-416, is void."
Renumber: subsequent sections

- END -

MINUTES

MONTANA HOUSE OF REPRESENTATIVES
59th LEGISLATURE - REGULAR SESSION

COMMITTEE ON HUMAN SERVICES

Call to Order: By **CHAIRMAN ARLENE BECKER**, on March 23, 2005 at 3:00 P.M., in Room 472 Capitol.

ROLL CALL

Members Present:
Rep. Arlene Becker, Chairman (D)
Rep. Tom Facey, Vice Chairman (D)
Rep. Don Roberts, Vice Chairman (R)
Rep. Mary Caferro (D)
Rep. Emelie Eaton (D)
Rep. Gordon R. Hendrick (R)
Rep. Teresa K. Henry (D)
Rep. William J. Jones (R)
Rep. Dave McAlpin (D)
Rep. Tom McGillvray (R)
Rep. Mike Milburn (R)
Rep. Art Noonan (D)
Rep. Ron Stoker (R)
Rep. Pat Wagman (R)
Rep. Bill Warden (R)
Rep. Jonathan Windy Boy (D)

Members Excused: None.

Members Absent: None.

Staff Present: Susan Fox, Legislative Branch
Mary Gay Wells, Committee Secretary

Please Note. These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:
Hearing & Date Posted: SJR 15, 3/18/2005
HJR 32, 3/18/2005
SB 324, 3/18/2005
SB 481, 3/18/2005
Executive Action:

HEARING ON SB 481

Sponsor: **SEN. VICKI COCCHIARELLA, SD 47, MISSOULA**

Opening Statement by Sponsor:

SEN. VICKI COCCHIARELLA opened the hearing on **SB 481.** She handed two exhibits to the Committee. One is acronyms and definitions of Workers' Compensation terms. The second exhibit is the beginning of the law regarding Workers' Compensation which is included in Title 39 under Labor. The declaration of policy is pertinent to the topic which is being presented today. She highlighted "(3) Montana's workers' compensation...are intended to be primarily self-administering." Workers, employers and anyone in Montana should be able to pick up this section of law and know what their benefits are and why and what they pay for. This bill merges 39-71, the Occupational Disease Act into 39-72, the Workers' Compensation Act. This will simplify the law and make the law comply to be self-administering. This should have been done long before the Supreme Court decisions forced the Legislature to address this issue.
EXHIBIT(huh64a01)
EXHIBIT(huh64a02)

The Interim Committee on Economic Affairs worked on this issue and included every interested entity involved. **SEN. COCCHIARELLA** believes that this bill will solve a problem in the world of Workers' Compensation and will comply with decisions of the Supreme Court: if a person has an occupational disease which has happened over more than one shift, that person needs to be treated the same as if they had an injury that occurred in one shift. That is the basic essence of the Court's decisions. Almost all of the Occupational Disease Act is being striken because now all the benefits would be the same. The definitions of occupational disease are being preserved for reporting requirements.

She asked the Committee to consider an amendment. She explained the amendments.
EXHIBIT(huh64a03)
{Tape: 1; Side: A; Approx. Time Counter: 0 - 12.5}

Proponents' Testimony:

George Wood, Executive Secretary, Montana Self-Insurers Association, explained that he represented employers not employees who self-insure under Plan 1 of the Act. He strongly supports SB 481.

Jacqueline Lenmark, American Insurance Association, represents 450 insurance companies many of whom write Workers' Compensation in Montana under Plan 2. It is the national trend to take occupational disease acts, repeal them, and include those provisions within the Workers' Compensation Act. It makes good sense and is a more appropriate way to treat this type of disease that results from employment. They support the bill and the amendment.

Nancy Butler, Montana State Fund, said they insure 26,000 employers in Montana. They are in full support of the bill and the amendment.

Bob Worthington, Montana Municipal Insurance Authority (MMIA), explained that MMIA is a self-insurance organization of cities and towns. This is a very good bill and urged the Committee to concur in the bill.

Jason Todhunter, Montana Logging Association, stated they have 600 members that employ five to seven people. This bill will simplify the Workers' Comp and make it easier for the workers and the adjusters to understand.

Jed Fitch, Montana Trial Lawyers Association, supported the amendment and submitted a handout that explained their support.
EXHIBIT(huh64a04)
{Tape: 1; Side: A; Approx. Time Counter: 12.5 - 18.3}

Shawn Bubb, Director of Insurance Services, Montana School Boards Association, explained they administer the self-insured program for the majority of the public schools. This is a good bill and they support the amendment as well.

Opponents' Testimony: None

Informational Testimony: None

Questions from Committee Members and Responses:

REP. MILBURN asked about the Interim Committee's reasoning for or against this particular issue. **SEN. COCCHIARELLA** responded that this bill was a subject of the Interim Committee. They did not, at the end, adopt any approach. They did recommend a bill that at least combined or put into law the Supreme Court's decisions that had been made. The consensus fell apart, but she felt this bill brought it back together.
{Tape: 1; Side: A; Approx. Time Counter: 18.3 - 20.7}

REP. STOKER wondered if the bill addressed any asbestos related disease. **SEN. COCCHIARELLA** explained that the bill does not change any policy in the State of Montana regarding any disease.

REP. STOKER asked how, in the past, an occupational disease was handled as a claim. **SEN. COCCHIARELLA** said that the Occupational Disease Act had been in effect since about 1959. Diseases rather than injuries, or in addition to injuries, became Workers' Comp claims. This bill changes nothing. It takes the two statutes and puts them together. It makes benefits the same which is what the Court ruled.

Closing by Sponsor:

The Sponsor closed.

REP. MCNUTT will carry the bill.
{Tape: 1; Side: A; Approx. Time Counter: 20.7 - 26.3}

HEARING ON HJ 32

Sponsor: REP. JON SESSO, HD 76, BUTTE

Opening Statement by Sponsor:

REP. JON SESSO opened the hearing on **HJ 32.** It would urge the Department of Health and Human Services to review their rules on provider payments and overpayments. These providers of wheel chairs and durable goods to patients who are on Medicaid, provide the services and submit their invoices for those services to DPHHS. Those invoices are paid in a timely manner by the Department and the providers continue on in their services. But because of the stringent rules of Medicaid and the Federal requirements therein, DPHHS is compelled to audit the providers sometimes as long as six years after the provision of the service. The Department is allowed by law to recover what are considered to be overpayments. These payments for services rendered, for some reason, do not fulfill all of the technical requirements of the Federal law. The problem is the service is a product that has been given to the patient, used by the patient and consequently there is no opportunity for that provider to get the equipment back.

REP. SESSO looked at the law concerning overpayment and thought to have that changed. That did not pass because of a large fiscal note. This Resolution seeks to remedy the situation not

by law but by a Resolution that would ask the Department to review its rules governing the submission of these invoices, overpayments and audits and try to provide a shorter period of finality to these providers and give some relief from this onerous process of being audited so far out after service. ***{Tape: 1; Side: A; Approx. Time Counter: 26.3 - 32}***

Proponents' Testimony:

Mike Calcaterra, Branch Manager, Norco Medical, Missoula, and President, Big Sky Association of Medical Equipment Suppliers, said that with the current rules of the Department, there is a very broad definition of overpayment. Anything that is in error is deemed to be an overpayment whether that error changes the necessity or not, and they recoup that money. There may be a service ordered by a physician, provided to a recipient, billed at the appropriate amount, supplied in the appropriate amount, but because there is a missing item, DPHHS considers that an overpayment. This could be years worth of services. They would like the Department to work with the suppliers. If a legitimate product was provided to an eligible recipient and paid in an appropriate manner, and a technical error or omission of a minor piece that wouldn't change the medical necessity and was not a fraudulent situation, the State could not recoup that money. ***{Tape: 1; Side: B; Approx. Time Counter: 0 - 2.6}***

Dan Harrington, Harrington's Surgical Supply, Butte, said that he had gone through an audit process and spent approximately three years in court trying to prove that he was right. He finally ended up in District Court and that Court ruled in his favor on every issue. It was a waste of time and money on his part and he thought if the Resolution could be passed, that hopefully would be a beginning. Something needs to be done.

Tom Mitchell, Harrington's Surgical Supply, Butte, has worked at Harrington's for twenty years. He explained the difficulties that faced medical supply companies. It is a service that people need and there are fewer and fewer Durable Medical Equipment (DME) providers in the state. He urged passage of HJ 32.

Robert Gervich, Billings stated that he is associated with a medical supply company in Billings. He was in support of HJ 32.

Maureen O'Reilly, Spectrum Medical, Great Falls, explained that they serve areas from Great Falls, to Browning, Harlem, White Sulphur, Helena and back to Great Falls. This is a very rural area but there are people who need this service. They have experienced the same type of situations as Mr. Calcaterra and

urged this Resolution be passed in order to have more direction in these cases and a better manual to follow.
{Tape: 1; Side: B; Approx. Time Counter: 2.6 - 6.8}

Opponents' Testimony: None

Informational Testimony:

Anna Whiting-Sorrel, Family Policy Advisor, Governor's Office, spoke that she had met with DPHHS and providers concerning this issue. Steps have already been taken to address the problem.

Mary Dalton, Administrator, Quality Assurance Division, DPHHS, explained that one of her duties in the Division is to do recoveries through the Surveillance Utilization Review system. This issue should have been solved before having to come to the Legislature. She pledged that it will be solved before the next session.

Questions from Committee Members and Responses:

REP. ROBERTS asked if an honest attempt can be construed as a dishonest attempt to be reimbursed because of the obliqueness of the rules. **Mr. Harrington** agreed totally. He believed that when they were audited there would be no problem. Because there were prescriptions that did not have a length of need or diagnosis on them that was not required by the Medicaid manual or by Medicare, they were taken to court.

REP. ROBERTS discussed ways that could alleviate some of the problems. He asked Mr. Harrington if these problems made him reluctant to participate in working with Medicaid. **Mr. Harrington** said that was very much in his mind and hoped that things could get back on track and they could work with Medicaid. He was in full support of prosecuting those who are truly trying to commit fraud.
{Tape: 1; Side: B; Approx. Time Counter: 6.8 - 12.7}

REP. MILBURN asked if the Department overpays someone unintentionally, does this Resolution say the State cannot come back and recoup that money. **Ms. Dalton** said that is not what the Resolution would do.

REP. MILBURN questioned the Whereas clause that spoke about the provider being responsible for the error even if the error was on the part of the Department. **Ms. Dalton** said the "Whereas" clauses were laying out the case for DME providers. The resolution calls for the Department to look at their rules and

procedures and make possible revisions to those rules and procedures.
{Tape: 1; Side: B; Approx. Time Counter: 12.7 - 14.4}

REP. STOKER said a six-year look back was quite long. He asked how many suppliers are in Montana. **Ms. Dalton** responded that there are 571 DME providers and 12,000 Medicaid providers.

REP. STOKER asked how often does the Department audit 571 DME providers. **Ms. Dalton** spoke again about the Surveillance Utilization Review. They run statistical samplings to see if one physician is different from another. They look at referrals from anyone. Since 2002, the Department's policy has been to go back only three years.

REP. STOKER asked about the practice of mark-up. **Ms. Dalton** explained that providers are in business and they set their prices based on their many expenses.

REP. STOKER asked Mr. Mitchell the same question. **Mr. Mitchell** said that in looking at a mark-up on gloves, there is an allowable set by Medicare and followed by Medicaid on most of the items they carry. Otherwise, it is a 25 percent discount off the usual and normal charge to Medicaid recipients.

REP. STOKER wondered how many of the 571 DME providers have reported an audit. **Mr. Mitchell** explained that those 571 providers include everyone such as a pharmacy in Two Dot. There are fewer than 50 full-line DMEs. Seventy-five percent of their members have gone through one of these audits and have complained to the Association.
{Tape: 1; Side: B; Approx. Time Counter: 14.4 - 21.1}

REP. NOONAN inquired if a report was being required of DPHHS after they had reviewed their rules and procedures. **REP. SESSO** said they did expect DPHHS to meet with the providers and to report their changes in the rules and procedures.

CHAIRMAN BECKER asked what a "clean claim" was. **REP. SESSO** explained that it has everything on the claim that is required. That is the conundrum here. The provider provides the service, the wheelchair is on the street, the claim is submitted and payment is made fairly quickly. The problem is by having to get the payment done quickly, they don't do the checking of the claim first. Most of the claims are fine, but when guidance is changed between the providing of the service and the audit, what may have been legitimate at the time of payment now becomes an error.

Closing by Sponsor:

REP. SESSO reiterated that this Resolution does not change the rules concerning true fraud and abuse. The intent is to give clear guidance to providers as they submit their claims.
{Tape: 1; Side: B; Approx. Time Counter: 21.1 - 29.3}

HEARING ON SB 324

Sponsor: SEN. JON TESTER, SD 15, BIG SANDY

Opening Statement by Sponsor:

SEN. JON TESTER opened the hearing on **SB 324.** The bill will provide meaningful drug benefits to the elderly, the disabled and the uninsured. Prescription drugs take a lot of dollars and healthcare is a major concern for Montanans.
{Tape: 1; Side: B; Approx. Time Counter: 29.3 - 32; Comments: SEN TESTER's opening continued onto Tape 2, Side A.}

The bill creates a prescription drug program that accesses Medicare, Part D that the Federal Government is introducing on January 1, 2006. It creates a pharmacy discount program for uninsured Montanans who make less than 250% of Federal Poverty Level (FPL). It creates educational materials for physicians and patients informing them of the costs and benefits of various drugs and provides for access to evidence-based research on the comparative effectiveness of prescription drugs. This bill will be funded through I-149 revenues.
{Tape: 2; Side: A; Approx. Time Counter: 0 - 2.2}

Proponents' Testimony:

REP. DON ROBERTS, HD 56, spoke that as an oral surgeon, he sees patients all the time who have to make a choice between shelter, food or other necessities. This bill will help them survive in a better way. Prescription drugs can be very expensive. Congress is helping and Montana needs to do all that they can to help the elderly, the disabled and the uninsured.
{Tape: 2; Side: A; Approx. Time Counter: 2.2 - 5.6}

John Morrison, State Auditor, explained that SB 324 is part of a larger picture of healthcare legislation that has come from I-149. He gave some background history on I-149. He urged the Committee to support the bill.
{Tape: 2; Side: A; Approx. Time Counter: 5.6 - 9.5}

Anna Whiting-Sorrel, Family Policy Advisor, Governor's Office, explained that she had some oversight and responsibility for DPHHS, Corrections and Industry and Labor. She stood in support of SB 324 and thanked the sponsors for bringing this bill forward at the Governor's request. The Governor directed her office to ensure that I-149 programs have sustainability on two levels: 1) the first was fiscal sustainability, and that is happening, 2) SB 324 would provide constraints within its program implementation. This program will be made available only to certain levels of poverty. In one program it will be 200% and in another it is 250%. DPHHS will only increase participation when they are confident that the necessary funds will be available in order to sustain the program.
{Tape: 2; Side: A; Approx. Time Counter: 9.5 - 13.2}

Claudia Clifford, Montana AARP, explained the bill completely and submitted her written copy. She also handed out a packet of information from AARP.
EXHIBIT (huh64a05)
EXHIBIT (huh64a06)
{Tape: 2; Side: A; Approx. Time Counter: 13.2 - 27}

Verner Bertolsen, Representing Himself, concurred with Ms. Clifford and urged a do concur.

Bill Kennedy, Commissioner, Yellowstone County, stood in support of SB 324. Yellowstone County had offered a general assistance program with pharmaceuticals and within six months the Deering Clinic came and asked for more money. There is a major need for help with prescription drugs.
{Tape: 2; Side: A; Approx. Time Counter: 27 - 28.4}

Mary Williams, Volunteer Advocate, AARP, spoke on behalf of Beverly Robinson of Helena. She submitted Ms. Robinson's testimony.
EXHIBIT (huh64a07)

Betty Beverly, Executive Director, Montana Senior Citizens Association, spoke in favor of the bill. Prescription drugs have been a big issue for them since 1993. Montana's senior citizens supported I-149 heavily. She urged a do concur.

Peter Wolfgram, Montana Pharmacists Association, gave his testimony and submitted a written copy.
EXHIBIT (huh64a08)
{Tape: 2; Side: A; Approx. Time Counter: 28.4 - 32}

Beda Lovitt, Montana Medical Association and Montana Psychiatric Association, spoke for these two groups and said they stand strongly behind the legislation. The doctors face daily the problems with the cost of prescriptions as they do their best in treating their patients.
{Tape: 2; Side: B; Approx. Time Counter: 0 - 0.6}

Jani McCall, Deaconess Billings Clinic, stood in strong support of the bill.

Chuck Hunter, DPHHS, spoke about the amendments that had been prepared for the sponsor. He encouraged the adoption of the amendments.
EXHIBIT(huh64a09)

Jim Aherns, Chairman, Alliance for a Healthy Montana, urged the Committee to support the bill.

Bonnie Adee, Mental Health Ombudsman, urged the Committee to support the bill.

Jim Smith, American Cancer Society, submitted a letter.
EXHIBIT(huh64a10)
{Tape: 2; Side: B; Approx. Time Counter: 0.6 - 2.2}

Opponents' Testimony: None

Informational Testimony: None

Questions from Committee Members and Responses:

REP. CAFERRO asked for an explanation of the potential cost savings with the consulting portion of the bill. **Ms. Clifford** replied that program is set up so that the State will pay a small consulting fee to the pharmacist and the consumer will pay a small fee as well. The pharmacists will give advise. In Wyoming, it was saving consumers between $350 and $420 a year.

REP. CAFERRO wondered if there are savings to the consumer, would there be savings to the whole system. **Ms. Clifford** said, "Yes."

REP. WINDY BOY inquired about the projected revenues that had been mentioned and asked if a smoking ban would have an effect on revenues. **Ms. Whiting-Sorrel** was not positive but responded that they had used the best figures possible and did not think it would have an adverse effect.

REP. WINDY BOY asked about the fiscal note and the reasons for two different levels of poverty being used. **Mr. Hunter** replied that there are two different parts of the program. For the Medicare Part D, that benefit would be available up to 200% FPL. For the new discount drug card program, that benefit would be available up to 250% FPL.
{Tape: 2; Side: B; Approx. Time Counter: 2.2 - 6.3}

REP. EATON inquired about the four areas that were to benefit from I-149. **SEN. TESTER** replied they were: 1) CHIP, 2) Medicaid provider rates, 3) prescription drug program, and 4) pooling and tax credits for employers who provide healthcare benefits.

REP. EATON asked if this bill takes all of the money that is raised. **SEN. TESTER** answered that this bill will take about $8.75 million. The projection for I-149 revenues is about $35 to $36 million.

REP. EATON asked about an effective date. **SEN. TESTER** said that the effective date is July 1, 2005. It accesses the Medicare Part D program on January 1, 2006.

REP. MCGILLVRAY asked Ms. Clifford why she thought a family of five could not afford their prescription drugs when their income is $57,000 a year. **Ms. Clifford** replied that the wrap-around program will only be available to people who currently qualify for Medicare. That program is for people over 65 and for those who are very disabled. There is a discount card that people can use to buy their drugs and this is for anyone who doesn't have a pharmacy benefit whether they are completely uninsured or if they have a little bit of insurance. That could help a family with that kind of income. When the uninsured pay for a prescription, they have to pay full retail price. Those who have insurance benefits don't pay full retail price.

REP. MCGILLVRAY could not believe that a family making $57,000 a year would not have insurance. **Ms. Clifford** replied that they might and then they would not qualify for a discount card.

REP. MCGILLVRAY felt that 250% FPL was too high. **Ms. Clifford** responded that 250% might be too high but they are trying to help the uninsured to the greatest extent possible. It doesn't cost the State anything once the program is started. It is self funding by the pharmaceutical company rebates.

REP. MCGILLVRAY asked if Ms. Clifford thought these programs would enable people who could otherwise afford insurance. **Ms. Clifford** again thought he had a good question. The discount

cards are not going to make prescriptions cheap. It would discount between 15% and 45% off the retail price.
{Tape: 2; Side: B; Approx. Time Counter: 6.3 - 11.7}

REP. MCGILLVRAY referred to the letter from Ms. Robinson (Exhibit 7). He asked REP. ROBERTS if he had an answer as to why prescription drugs have become so expensive. **REP. ROBERTS** replied that medicines now require about $800 million worth of trials and review before they become available to the public. There is a certain amount of time for patents to clear. People are living longer and there is a greater need for medications. There are orphan drugs which are drugs that take care of less than 5,000 people. Those drugs are very expensive and return a lower profit. Litigation has also become a factor in the problem.

REP. MCGILLVRAY asked if Montana and the country are moving toward socialized medicine. **REP. ROBERTS** replied that people are living so much longer and he felt that had come about because of new public health procedures.
{Tape: 2; Side: B; Approx. Time Counter: 11.7 - 14.8}

REP. STOKER wondered if pharmacies would handle Lipitor under the card program where the patient would pay $4.70 and the State would get a four percent rebate. **Mr. Wolfgram** explained how the program worked. The dispensing fee is $4.70 which is over what he would have to pay for the drug. It is a negotiated selling price to the patient. It would not be just $4.70 paid to the pharmacy.

REP. STOKER again asked Mr. Wolfgram if he would be willing to handle a $100 inventory of Lipitor on the shelf for $4.70. **Mr. Wolfgram** said he has four pharmacies and they do a significant amount of Medicaid business. This would be a plan similar to that and he would do that.

REP. WAGMAN asked if the sponsor would be willing to accept an amendment to amend the bill to say that if the revenue source dries up in the future, money would not come out of the General Fund. **SEN. TESTER** felt that would be fine; but this program, as it evolves, should be a good enough program so that the Legislature would be willing to fund it.

Closing by Sponsor:

The Sponsor closed.

HEARING ON SJ 15

Sponsor: **SEN. CAROL WILLIAMS, SD 46, MISSOULA**

Opening Statement by Sponsor:

SEN. CAROL WILLIAMS opened the hearing on **SJ 15.** Polybrominated diphenyl ethers (PBDEs) are man-made chemicals commonly added to plastics, foam, appliances, computers, and furniture. They are toxic, bio-accumulative and can be replaced with safer alternatives. Making household products fire-resistant is a good thing, but flame retardants are causing new problems as they work to solve an old one. PBDEs are stored in a mother's body and are released during pregnancy. They are also known to accumulate in breast milk and can enter the bodies of babies while breast feeding. This Resolution supports both safe and non-toxic solutions. Americans have been shown to have a remarkably high exposure; more than most other people around the world. The Resolution doesn't act to ban PBDEs but does support a phase-out.
{Tape: 2; Side: B; Approx. Time Counter: 14.8 - 24}

Proponents' Testimony:

Alexandra Gorman, Director, Science and Research for Women's Voice for the Earth, gave her testimony and handed out fact sheets on PBDEs.
EXHIBIT(huh64a11)
EXHIBIT(huh64a12)
EXHIBIT(huh64a13)
{Tape: 2; Side: B; Approx. Time Counter: 24 - 29.2}

Laurie Yung, Mother, Missoula, gave her testimony and submitted her written testimony.
EXHIBIT(huh64a14)
{Tape: 2; Side: B; Approx. Time Counter: 29.2 - 32; Comments: Ms. Yung's testimony continued on Tape 3, Side A; Approx. Time Counter: 00 - 0.5}

Anna Whiting-Sorrel, Family Policy Advisor, Governor's Office, stood in support of the Resolution. This will strengthen Montana families. She urged the Committee's support.
{Tape: 3; Side: A; Approx. Time Counter: 0.5 - 2.2}

Dori Gilels, Northern Rockies Program Director of Women's Voices for the Earth, Missoula, gave her testimony and submitted her written testimony. She also submitted a letter from Rebekah Griffin and a joint letter by Women's Voices of the Earth and Dr.

Dana Headapohl, Director of Occupational & Environmental Health Services at St. Patrick Hospital in Missoula.
EXHIBIT(huh64a15)
EXHIBIT(huh64a16)
EXHIBIT(huh64a17)

Florence Williams, Mother, Helena, said that she had written an article two months ago on breast milk and flame retardants. She submitted that article.
EXHIBIT(huh64a18)
{Tape: 3; Side: A; Approx. Time Counter: 2.2 - 9}

Mark Augenas, Montana Trout Unlimited, said that PBDEs accumulate in fish and people eat the fish. That is one way people get elevated amounts of PBDEs in their body. This bill will help not only mothers but fish.

Leslie McClean, Montana Environmental Information Center, stood in strong support for the Resolution. She concurred with the previous testimony.
{Tape: 3; Side: A; Approx. Time Counter: 9 - 10.1}

REP. GAIL GUTSCHE, HD 99, Missoula, urged the Committee to consider the policy question. SJ 15 would make a policy statement for Montana.

Opponents' Testimony:

Glade Squires, Vice President of Government Affairs, Ameribrom, Inc. and Bromine Science and Environmental Forum (BSEF), stood as an opponent of SJ 15. He gave his testimony and submitted a written copy. As a chemist, he introduced his testimony as fact.
EXHIBIT(huh64a19)
{Tape: 3; Side: A; Approx. Time Counter: 10.1 - 20.8}

Haley Beaudry, BSEF, said that he had spoken with Montana State Fire Marshals. The National Association of State Fire Marshals had issued a document. He read a small portion. "They asked state legislators to postpone any further action on bills banning PBDEs to avoid unnecessarily exposing their constituents to the increased risk of fire. The debate creates an unnecessary and unconstructive conflict between fire safety and environmental officials. It has resulted in the dissemination of much inaccurate information and is a serious distraction for those who are seeking fair and honest solutions." He felt that if PBDEs are as bad as has been presented, a bill to ban them should be in order, not just a resolution. A ban would be a great detriment to Montana. There are too many things that have PBDEs in them and it would be impossible to ban everything. He also spoke for

Pat Klinch who is the Legislative Chairman of the Montana Professional Firefighters. He signed in as an opponent but could not stay to testify because he had to go to work.
{Tape: 3; Side: A; Approx. Time Counter: 20.8 - 24.4}

Informational Testimony: None

Questions from Committee Members and Responses:

REP. MCALPIN asked if it would be less expensive to produce fire retardants with bromines in them than the alternative. **Mr. Beaudry** answered, "Yes, they are." He believed that it was a factor of four times. By taking the bromine solutions out and replacing them with one of the expensive fire retardants, a lot of the materials that have been made fire retardant won't be around any more or the price will go up.

REP. MCALPIN asked if he would be in opposition to the bill if it cost the same to produce fire retardants without bromine solutions. **Mr. Beaudry** thought he would still be in opposition because decisions should be made on a scientific basis.

REP. MCALPIN asked if the studies that Mr. Beaudry referred to had been peer reviewed. **Mr. Beaudry** replied that they had been peer reviewed and the European study that had been referred to earlier was not only peer reviewed but also reviewed by scientists from each country of the European Union.

REP. MCALPIN redirected his question to Ms. Gorman. **Ms. Gorman** replied that she did not know if the studies had been peer reviewed. As for the European Union study, she had other opinions that declared there were serious problems with the conclusions of that report.
{Tape: 3; Side: A; Approx. Time Counter: 24.4 - 27.9}

REP. STOKER asked if this problem is across Montana or concentrated in certain areas. **Ms. Gorman** said that they were not aware of any one area in particular. The studies of breast milk were conducted in Missoula and Helena. The levels ranged but there were little differences. They had not found one part of the country to have considerably higher levels.

REP. STOKER wondered if there could be an individual sensitivity that would make one mother more susceptible. **Ms. Gorman** replied that would be good information to have but that kind of research has not been done as of yet.

REP. STOKER inquired if there were any chemicals or foods that should be avoided that would cleanse the body. **Ms. Gorman** did

not have research on that either. One of the best ways to rid the body is to breast feed but then the mother is passing it onto her child.
{Tape: 3; Side: A; Approx. Time Counter: 27.9 - 30.9}

REP. NOONAN commented that both sides have referenced that science should bear out. With the three bromides of penta, octa and deca, it seems to imply they were discovered over time. For penta and octa, there is general agreement they are toxic and should be taken from the environment. **Mr. Squires** said that was correct and that is where the manufacturer of penta and octa stepped up, ceased production and consulted with the U.S. EPA to prevent any future production. The terms penta, octa and deca refer to the number of bromine atoms in a molecule: five, eight and ten. Penta is a liquid material mainly used in polyurethane foam. It would have a propensity to find its way out of the foam and into the environment quite easily. The octa was a fairly low use material. The deca is ten bromines in the molecule, is solid and has no vapor pressure. It is used mainly in plastic materials.
{Tape: 3; Side: A; Approx. Time Counter: 30.9 - 32}

REP. NOONAN understood that these bromines are still out there in products. He asked if Mr. Squires' organization was the one who declared that the first two were toxic. **Mr. Squires** replied that it was not their findings. The findings of penta in breast milk in Sweden was done by an independent researcher. Sweden identified that. There was only one manufacturer of penta from his group. they had come forward and discussed with the European Union that penta was not used solely as a flame retardant. It had been used as a high density fluid in the drilling of oil wells in the North Sea.

REP. NOONAN wondered about the research and where it had come from. **Mr. Squires** responded that the testing of their products and the chemicals they produce are in compliance and tested to EPA standards as well as to European standards. They have also funded studies of bromine solutions.

CHAIRMAN BECKER said that questions would be more than welcomed and asked the Representatives to give their questions to proponents and opponents. Their responses would be read to the Committee at Executive Action.

Closing by Sponsor:

The Sponsor closed.
{Tape: 3; Side: B; Approx. Time Counter: 0 - 4.8}

ADJOURNMENT

Adjournment: 6:00 P.M.

_____
REP. ARLENE BECKER, Chairman

_____
MARY GAY WELLS, Secretary

AB/mw

Additional Exhibits:

EXHIBIT(huh64aad0.PDF)

EXHIBIT 1
DATE 3-23-05
SB 481

Workers' Compensation Terms – Acronyms and Definitions

AWW – Average Weekly Wage

The mean weekly earnings of all employees under covered employment, as defined and established annually by the department. It is established at the nearest whole dollar number and must be adopted by the department before July 1 of each year. -- Defined in 39-71-116(4)

FCE - Functional Capacities Evaluation.

Used in 39-71-605 (4): "A claimant is required, upon a written request of an insurer, to submit to a functional capacities evaluation conducted by a licensed physical or occupational therapist."

IME - Independent Medical Examination

Medical exams referenced in 39-71-605.

Impairment Rating

Defined in 39-71-711 (1) An impairment rating:
(a) is a purely medical determination and must be determined by an impairment evaluator after a claimant has reached maximum healing;
(b) must be based on the current edition of the Guides to Evaluation of Permanent Impairment published by the American medical association;
(c) must be expressed as a percentage of the whole person; and
(d) must be established by objective medical findings.
(2) A claimant or insurer, or both, may obtain an impairment rating from an evaluator who is a medical doctor or from an evaluator who is a chiropractor if the injury falls within the scope of chiropractic practice. If the claimant and insurer cannot agree upon the rating, the mediation procedure in part 24 of this chapter must be followed.
(3) An evaluator must be a physician licensed under Title 37, chapter 3, except if the claimant's treating physician is a chiropractor, the evaluator may be a chiropractor who is certified as an evaluator under chapter 12.

Injury

1) "**Injury**" or "injured" means:
(a) internal or external physical harm to the body that is established by objective medical findings;
(b) damage to prosthetic devices or appliances, except for damage to eyeglasses, contact lenses, dentures, or hearing aids; or
(c) death.
(2) An injury is caused by an accident. An accident is:
(a) an unexpected traumatic incident or unusual strain;
(b) identifiable by time and place of occurrence;
(c) identifiable by member or part of the body affected; and
(d) caused by a specific event on a single day or during a single work shift. Defined in 39-71-119.
(3) "Injury" or "injured" does not mean a physical or mental condition arising from:
(a) emotional or mental stress; or
(b) a nonphysical stimulus or activity.
(4) "Injury" or "injured" does not include a disease that is not caused by an accident.
(5) (a) A cardiovascular, pulmonary, respiratory, or other disease, cerebrovascular accident, or myocardial infarction suffered by a worker is an injury only if the accident is the primary cause of the physical condition in relation to other factors contributing to the physical condition.
(b) "Primary cause", as used in subsection (5)(a), means a cause that, with a reasonable degree of medical certainty, is responsible for more than 50% of the physical condition.

MMI – Maximum Medical Improvement

Also, medical stability as defined in 39-71-116(18): "Medical stability", "maximum healing", or "maximum medical healing" means a point in the healing process when further material improvement would not be reasonably expected from primary medical treatment.

OD – Occupational Disease

"**Occupational disease**" means harm, damage, or death as set forth in 39-71-119(1) [see definition above for injury] arising out of or contracted in the course and scope of employment and caused by events occurring on more than a single day or work shift. The term does not include a physical or mental condition arising from emotional or mental stress or from a nonphysical stimulus or activity. Definition in 39-72-102.

Objective Medical Findings or Opinion

"**Objective medical findings**" means medical evidence, including range of motion, atrophy, muscle strength, muscle spasm, or other diagnostic evidence, substantiated by clinical findings. Defined in 39-71-116(19)

Plan 1 – Self-Insurers' Workers' Compensation Plan

Definition in 39-71-2101. (1) An employer may elect to be bound by compensation **plan No. 1** upon furnishing satisfactory proof to the department and the Montana self-insurers guaranty fund of solvency and financial ability to pay the compensation and benefits provided for in this chapter and to discharge all liabilities that are reasonably likely to be incurred during the fiscal year for which the election is effective. The employer may, by order of the department and with the concurrence of the guaranty fund, make the payments directly to employees as they become entitled to receive payments under the terms and conditions of this chapter.

(2) Employers who comply with the provisions of this chapter and who are participating in collectively bargained, jointly administered Taft-Hartley trust funds are

Workers' Compensation Terms – Acronyms and Definitions

eligible to provide self-insured workers' compensation benefits for their employees.

Plan 2 – Workers' Compensation Private Insurers

Private insurance companies that transact workers' compensation business. Defined partially in 39-71-116 under: "Insurer" means an employer bound by compensation plan No. 1, **an insurance company transacting business under compensation plan No. 2**, or the state fund under compensation plan No. 3.

Plan 3 – Montana State Compensation Fund

"State fund" defined in 39-71-2312 as the state compensation insurance fund provided for in 39-71-2313. Also known as compensation plan No. 3 or **plan No. 3.**

Exclusive for state employees – 39-71-403.

PPD - Permanent Partial Disability

A physical condition in which a worker, after reaching maximum medical healing:
(a) has a permanent impairment established by objective medical findings;
(b) is able to return to work in some capacity but the permanent impairment impairs the worker's ability to work; and
(c) has an actual wage loss as a result of the injury. Defined in 39-71-116(23)

PPD RATE – Determined under 39-71-703.

PTD - Permanent Total Disability

"**Permanent total disability**" means a physical condition resulting from injury as defined in this chapter, after a worker reaches maximum medical healing, in which a worker does not have a reasonable prospect of physically performing regular employment. Regular employment means work on a recurring basis performed for remuneration in a trade, business, profession, or other occupation in this state. Lack of immediate job openings is not a factor to be considered in determining if a worker is permanently totally disabled. Defined in 39-71-116(24)

Compensation determined under 39-71-702

TPD – Temporary Partial Disability

"**Temporary partial disability**" means a physical condition resulting from an injury, as defined in 39-71-119, in which a worker, prior to maximum healing:
(a) is temporarily unable to return to the position held at the time of injury because of a medically determined physical restriction;
(b) returns to work in a modified or alternative employment; and
(c) suffers a partial wage loss. Defined in 39-71-116(32)

Compensation determined under 39-71-712

TTD - Temporary Total Disability

"**Temporary total disability**" means a physical condition resulting from an injury, as defined in this chapter, that results in total loss of wages and exists until the injured worker reaches maximum medical healing. Defined in 39-71-116(34)

TTD RATE – Determined under 39-71-701

Treating Physician

"**Treating physician**" means a person who is primarily responsible for the treatment of a worker's compensable injury and is:
(a) a physician licensed by the state of Montana under Title 37, chapter 3, and has admitting privileges to practice in one or more hospitals, if any, in the area where the physician is located;
(b) a chiropractor licensed by the state of Montana under Title 37, chapter 12;
(c) a physician assistant-certified licensed by the state of Montana under Title 37, chapter 20, if there is not a treating physician, as provided for in subsection (36)(a), in the area where the physician assistant-certified is located;
(d) an osteopath licensed by the state of Montana under Title 37, chapter 3;
(e) a dentist licensed by the state of Montana under Title 37, chapter 4;
(f) for a claimant residing out of state or upon approval of the insurer, a treating physician defined in subsections (36)(a) through (36)(e) who is licensed or certified in another state; or
(g) an advanced practice registered nurse licensed by the state of Montana under Title 37, chapter 8, recognized by the board of nursing as a nurse practitioner or a clinical nurse specialist, and practicing in consultation with a physician licensed under Title 37, chapter 3, if there is not a treating physician, as provided for in subsection (36)(a), in the area in which the advanced practice registered nurse is located. Definition in 39-71-116(36)

EXHIBIT 2
DATE 3-23-05
SB 481

History: En. Sec. 1, Ch. 96, L. 1915; re-en. Sec. 2817, R.C.M. 1921; re-en. Sec. 2817, R.C.M. 1935; R.C.M. 1947, 92-102; amd. Sec. 52, Ch. 397, L. 1979.

Cross-References

Compensation plan No. 1, Title 39, ch. 71, part 21.
Compensation plan No. 2, Title 39, ch. 71, part 22.
Compensation plan No. 3, Title 39, ch. 71, part 23.

39-71-103. Compensation provisions. The compensation provisions of this chapter, whenever referred to, shall be held to include the provisions of compensation plan No. 1, 2, or 3 and all other sections of this chapter applicable to the same or any part thereof.

History: En. Sec. 1, Ch. 96, L. 1915; re-en. Sec. 2818, R.C.M. 1921; re-en. Sec. 2818, R.C.M. 1935; R.C.M. 1947, 92-103.

39-71-104. Repealed. Sec. 68, Ch. 464, L. 1987.

History: En. Sec. 24, Ch. 96, L. 1915; re-en. Sec. 2964, R.C.M. 1921; re-en. Sec. 2964, R.C.M. 1935; R.C.M. 1947, 92-838.

39-71-105. Declaration of public policy. For the purposes of interpreting and applying Title 39, chapters 71 and 72, the following is the public policy of this state:

(1) It is an objective of the Montana workers' compensation system to provide, without regard to fault, wage supplement and medical benefits to a worker suffering from a work-related injury or disease. Wage-loss benefits are not intended to make an injured worker whole; they are intended to assist a worker at a reasonable cost to the employer. Within that limitation, the wage-loss benefit should bear a reasonable relationship to actual wages lost as a result of a work-related injury or disease.

(2) A worker's removal from the work force due to a work-related injury or disease has a negative impact on the worker, the worker's family, the employer, and the general public. Therefore, it is an objective of the workers' compensation system to return a worker to work as soon as possible after the worker has suffered a work-related injury or disease.

(3) Montana's workers' compensation and occupational disease insurance systems are intended to be primarily self-administering. Claimants should be able to speedily obtain benefits, and employers should be able to provide coverage at reasonably constant rates. To meet these objectives, the system must be designed to minimize reliance upon lawyers and the courts to obtain benefits and interpret liabilities.

(4) Title 39, chapters 71 and 72, must be construed according to their terms and not liberally in favor of any party.

(5) It is the intent of the legislature that stress claims, often referred to as "mental-mental claims" and "mental-physical claims", are not compensable under Montana's workers' compensation and occupational disease laws. The legislature recognizes that these claims are difficult to objectively verify and that the claims have a potential to place an economic burden on the workers' compensation and occupational disease system. The legislature also recognizes that there are other states that do not provide compensation for various categories of stress claims and that stress claims have presented economic problems for certain other jurisdictions. In addition, not all injuries are compensable under the present system, as is the case with repetitive injury claims, and it is within the legislature's authority to define the limits of the workers' compensation and occupational disease system.

History: En. Sec. 1, Ch. 464, L. 1987; amd. Sec. 1, Ch. 630, L. 1993.

39-71-106. No liability for reporting violation. A person, including but not limited to an insurer or an employer, may not be held liable for civil damages as a result of reporting in good faith information that the person believes proves a violation of the provisions of chapter 72 or this chapter.

History: En. Sec. 17, Ch. 619, L. 1993.

39-71-107. Insurers to act promptly on claims — in-state adjusters. (1) Pursuant to the public policy stated in 39-71-105, prompt claims handling practices are necessary to provide appropriate service to injured workers, to employers, and to providers who are the customers of the workers' compensation system.

(2) All workers' compensation and occupational disease claims filed pursuant to the Workers' Compensation Act and the Occupational Disease Act of Montana must be adjusted by a person in Montana. For a claim to be considered as adjusted by a person in Montana, the person

EXHIBIT 3
DATE 3-23-05
SB 481

Amendments to Senate Bill No. 481
3rd Reading Copy

Requested by Senator Vicki Cocchiarella

For the House Human Services Committee

Prepared by Pat Murdo
March 23, 2005 (8:14am)

1. Page 22, line 17.
Strike: "more than 50% responsible for"
Insert: "the major contributing cause of"

2. Page 38, line 3.
Insert: "NEW SECTION. **Section 41. Direction to code commissioner.** The code commissioner is directed to change any reference to chapter 72 of Title 39 that appears in legislation enacted by the 2005 legislature to a reference to chapter 71 of Title 39."
Renumber: subsequent sections

- END -

EXHIBIT 4
DATE 3-23-05
SB 481

The Montana Trial Lawyers Association supports SB 481.

The merger of Occupational Disease and Workers' Compensation in SB 481 is an excellent and long overdue change.

This bill corrects constitutional problems of equal protection between the two acts identified by the Supreme Court. The bill essentially ratifies what Insurers and Employers are currently doing in regard to occupational disease. It treats injured workers fairly and equitably, whether that worker was injured in a mishap that took place in an instant or suffers from an occupational disease that developed over years of exposure to a harmful circumstance in the workplace.

The Montana Trial Lawyers Association believes that **one amendment** is necessary to make this bill better, for both workers and for employers.

The Amendment:
Page 22, line 17:
STRIKE: "more than 50% responsible for"
INSERT: "the major contributing factor of"

The Reason:
The 50% requirement is a change in current law. With that exception, the rest of SB 481 is an outright merger of the two acts. Why is this a problem?

- **First:** The current language of the bill requires a doctor to determine among several possible causes whether or not the work related causes were 50% of the overall cause. That would be fine if there were only two factors in play - work was or was not the major contributing factor. But when there are several factors that are possibly a cause, how can the doctor say with certainty that work was only 49% of the cause, and the other 4 or 5 causes together were 51%? That is not fair to the doctor, and it is not fair to the worker.
- **Second:** Assuming that the doctor could say with certainty that work was 49% of the cause of an occupational disease, and the remaining factors (such as genetics, a hobby, environmental factors, etc) were each 10-15%, is it fair to say that workers' compensation should not cover that worker? Without the work related causes, it is likely the disease would never have manifested itself, yet we are going to deny workers compensation because work was only 49% of the cause, and was clearly the ***Major Contributing Factor.***
- **Third:** If we do bar a worker whose occupational disease was 49% caused by work, we also exempt them from the ***exclusive remedy*** provisions of work comp. That results in the worker filing a civil ***lawsuit against the employer***. And the employer is not covered by the work comp insurance that the employer has paid for in such a lawsuit. This is a bad result for the worker and for the employer.

For the above reasons, MTLA supports amending SB 481, striking 50%, and inserting "major contributing factor." It is fair to workers and fair to employers. And it avoids recreating the problem that SB 481 is fixing, that the differences between the two Acts violates equal protection.

Jed C. Fitch
Montana Trial Lawyers Association
443-3124

MINUTES

MONTANA HOUSE OF REPRESENTATIVES
59th LEGISLATURE - REGULAR SESSION

COMMITTEE ON HUMAN SERVICES

Call to Order: By **CHAIRMAN ARLENE BECKER**, on April 1, 2005 at 3:00 P.M., in Room 472 Capitol.

ROLL CALL

Members Present:
Rep. Arlene Becker, Chairman (D)
Rep. Tom Facey, Vice Chairman (D)
Rep. Don Roberts, Vice Chairman (R)
Rep. Mary Caferro (D)
Rep. Emelie Eaton (D)
Rep. Gordon R. Hendrick (R)
Rep. Teresa K. Henry (D)
Rep. William J. Jones (R)
Rep. Dave McAlpin (D)
Rep. Tom McGillvray (R)
Rep. Mike Milburn (R)
Rep. Art Noonan (D)
Rep. Ron Stoker (R)
Rep. Bill Warden (R)

Members Excused: Rep. Pat Wagman (R)
Rep. Jonathan Windy Boy (D)

Members Absent: None.

Staff Present: Mary Gay Wells, Committee Secretary
Susan Fox, Legislative Branch

Please Note. These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:
Hearing & Date Posted:
Executive Action: SJ 15 Tied; SB 33 Be Concurred In
SB 46 Be Concurred In
SB 481 Be Concurred In As Amended
SB 328 Be Concurred In As Amended
SB 154 Be Concurred In As Amended
SB 324 Be Concurred In As Amended

EXECUTIVE ACTION ON SB 324

Motion: REP. ROBERTS moved that SB 324 BE CONCURRED IN.

Motion: REP. ROBERTS moved that SB 324 BE AMENDED.
EXHIBIT(huh69a01)

Discussion:

REP. ROBERTS explained that the amendment was a consensus amendment with the pharmaceuticals, the Governor's Office, and SEN. TESTER.

Vote: Motion carried unanimously by voice vote 16-0. REP. WAGMAN and REP. WINDY BOY voted by proxy.

Motion: REP. ROBERTS moved that SB 324 BE AMENDED.
EXHIBIT(huh69a02)

Discussion:

Ms. Fox explained that the amendment is a concept that is applied to all the different I-149 designations either in Appropriations or HB 2. The coordination instruction applies to SB 324 and HB 667. It is intended to create that sustainability reserve. She continued to explain and read each section.
{Tape: 1; Side: A; Approx. Time Counter: 0 - 7.0}

REP. ROBERTS read a portion of a letter from Budget Director Ewer.
EXHIBIT(huh69a03)
{Tape: 1; Side: A; Approx. Time Counter: 6 - 8.8}

REP. WARDEN asked if the language was the same as used in the bill for the Small Business Health Insurance Assistance Plan. **Ms. Fox** answered, "Yes, for the most part, but there have been some slight changes. The December trigger is new language. Other than that, the concept is the same."

REP. WARDEN said that there are two bills that have a $25 million floor before certain things happen. He asked if there were two $25 million bills. **Ms. Fox** said, "No, it is the same $25 million."

REP. MCALPIN supported the amendment. The revenues have turned around. The Budget Office is comfortable with the projected revenue figures. The bill states that Montana will not spend money that is not available.

REP. ROBERTS said that once the program starts and prescriptions are being filled, the drug companies will give a rebate back to the State. This will help sustain the availability of revenue.

REP. STOKER said that he had seen a different set of numbers. He gave statistics that showed a large drop in volume. People are either giving up cigarettes or a lot of contraband is going on which includes a great deal of buying that is not going through the tax system. He was in favor of the bill, but would only vote for the bill if there was only the $25 million and no shifting of General Funds to pick up the slack.
{Tape: 1; Side: A; Approx. Time Counter: 8.8 - 15.1}

Vote: Motion carried unanimously by voice vote 16-0. REP. WAGMAN and REP. WINDY BOY voted by proxy.

Motion: REP. ROBERTS moved that SB 324 BE CONCEPTUALLY AMENDED TO MOVE A SECTION OF THE BILL ON PAGE 2, LINES 5-13 AND PUT IT ON PAGE 5, LINE 10.

Discussion:

REP. ROBERTS explained that an amendment made by the Senate had been put into the wrong section of the bill.

Vote: Motion carried unanimously by voice vote 16-0. REP. WAGMAN and REP. WINDY BOY voted by proxy.

Motion: REP. MCGILLVRAY moved that SB 324 BE CONCEPTUALLY AMENDED TO CHANGE THE FPL ON PAGE 1, LINE 22 FROM 200% TO 150%; ON PAGE 3, LINE 27 FROM 250% TO 150%; ON PAGE 4, LINE 27 FROM 250% TO 150%; AND ON PAGE 5, LINE 14 FROM 250% TO 150%.

Discussion:

REP. MCGILLVRAY felt that prescription drug costs are a major problem for needy seniors in Montana. SB 324 is creating an entitlement for a much broader class of citizens than the most needy. By making the benefits go up to 250% of FPL, the poverty level is no longer being talked about. The poverty level of 250% for a family with three children is nearly $57,000 a year. This creates financial dependence and an entitlement mentality. In the long run, it creates more, not less, dependence on government.
{Tape: 1; Side: A; Approx. Time Counter: 15.1 - 19.6}

REP. ROBERTS offered some research that he had done. He read the results. Hawaii uses 350% of FPL. Most people with a higher

level of income are not going to get involved in the program. With unique cases, that kind of income can disappear quickly with high-cost medications. The State will have the ability to assist them. He further reminded the Committee that this is a rebate program. He read some further results.
EXHIBIT(huh69a04)
{Tape: 1; Side: A; Approx. Time Counter: 19.6 - 23.6}

Vote: Motion failed 7-9 by roll call vote with REP. HENDRICK, REP. JONES, REP. MCGILLVRAY, REP. MILBURN, REP. STOKER, REP. WAGMAN, and REP. WARDEN voting aye. REP. WAGMAN and REP. WINDY BOY voted by proxy.

Motion: REP. ROBERTS moved that SB 324 BE CONCURRED IN AS AMENDED.

Discussion:

REP. MILBURN questioned if the eligibility rules on Page 5, Line 12 apply to those who do have insurance and have a high deductible and thus provide them with coverage. **REP. ROBERTS** responded that the program will not be expended. This is for those who are truly needy. This is for those who are too rich for Medicaid and too poor for insurance.

REP. MILBURN wondered, "If a family of five with $30,000 has a policy with a high deductible, would they be able to get coverage?" **REP. ROBERTS** said that if they had high-cost prescriptions, they could get coverage but if they can take care of it on their own, that would be good.

REP. MILBURN read from the bill that a family would not be able to have prescription drug coverage in order to be eligible or they would have to provide documentation that they had exceeded the coverage of the individual drug benefits. **Claudia Clifford, AARP,** said that REP. MILBURN was correct. This bill, as written, would not cover someone with a high deductible plan. What is available for the uninsured is a discount card. It is not coverage of any sort. It is just a discount with what the State can arrange through the program which would make the drug somewhat affordable. The bill could be improved to insert language to say that if someone had a $5,000 deductible or higher, they could qualify for the discount card. The whole purpose of the discount card is to get as many people in the pool as possible, so when the State is negotiating the rebates with the drug companies, the State would get the best possible deal.

REP. MILBURN thought the bill was a good idea, but needs some work. He did not feel that the really needy people would get as much as they could with such a high percent of FPL. The bill seems to be punishing those who are being responsible and seems to be an incentive to not buy health insurance.

REP. ROBERTS inquired about what REP. MILBURN had been talking about. His research indicated that the prescription drug program would not cause people to drop insurance coverage or even discourage them from getting coverage if they can afford it. The discounts will be 15% to 40% which would leave the consumer paying 85% to 60% of the cost. Insurance coverage is a far better deal for two reasons: 1) the out-of-pocket expense is less, and 2) so is insurance for the patient when they need many expensive drugs. He felt there was more incentive to get and keep insurance coverage.
{Tape: 1; Side: A; Approx. Time Counter: 23.6 - 31.5. REP. WAGMAN had returned to the hearing and made his motion at this point and continued onto Tape: 1, Side: B.}

Motion: REP. WAGMAN moved that SB 324 BE AMENDED.
EXHIBIT(huh69a05)

Discussion:

REP. WAGMAN explained that he had asked SEN. TESTER if he would be agreeable to amend the bill.
{Tape: 1; Side: B; Approx. Time Counter: 0 - 1}

REP. MCALPIN asked if SEN. TESTER had seen the amendment. **REP. WAGMAN** said that he had just seen the amendment. SEN. TESTER may have seen the amendment because it is similar to an amendment that was placed on SB 667.

Ms. Fox explained that the language was parallel to the language put in SB 667. Technically, the hands of future legislators cannot be bound, but the language says, "Don't expect this to be automatically funded." It would have to have a specific line item in the general appropriations bill. It does leave it open if future legislators choose to do that, but it does give a warning that there is no expectation that just because this is on the books, it will be funded. She had spoken to SEN. TESTER about this issue and he was not concerned about this amendment.

REP. FACEY asked the Budget Director to comment on the amendment. **Director David Ewer, Budget Director**, said that the amendment states that if there is not enough money from the tobacco tax, this program would not be considered under present law and the

appropriations process would have to have a line item to fund the program.

Vote: Motion to amend carried 13-3 by roll call vote with REP. CAFERRO, REP. MCALPIN, and REP. NOONAN voting no. REP. WINDY BOY voted by proxy.

REP. NOONAN addressed REP. MILBURN's concerns about encouraging people to be responsible of which he was in agreement. He felt that since needy people are covered by different programs, it helps to pay for prevention rather than paying to pick up the pieces.

REP. CAFERRO said that many people do have insurance and they don't have access to many of these programs. She felt that it was too bad they were going to be excluded from this program. ***{Tape: 1; Side: B; Approx. Time Counter: 1 - 6.1. REP. WAGMAN left the hearing.}***

REP. HENDRICK said that many are caught in that situation. He has a costly insurance premium, but would rather pay that than have someone else not able to get in this program.

Vote: Motion to BE CONCURRED IN AS AMENDED carried 15-1 by roll call vote with REP. MILBURN voting no. REP. WAGMAN and REP. WINDY BOY voted by proxy.

REP. ROBERTS will carry the bill.
{Tape: 1; Side: B; Approx. Time Counter: 6.1 - 8.4. REP. WAGMAN returned to the hearing.}

EXECUTIVE ACTION ON SB 481

Motion: REP. FACEY moved that SB 481 BE CONCURRED IN.

Motion: REP. FACEY moved that SB 481 BE AMENDED.
EXHIBIT(huh69a06)

Discussion:

REP. FACEY explained the amendments. The insurers, trial lawyers, etc. concurred.

Vote: Motion carried 16-0 by voice vote. REP. WINDY BOY voted by proxy.

Motion: **REP. FACEY moved that SB 481 BE CONCURRED IN AS AMENDED.**

Discussion:

REP. MCGILLVRAY asked what happens if the bill doesn't pass.
REP. FACEY said that nothing would happen, but the bill is merely condensing law to make an injury and an illness to be handled in the same way. This is a self-administered law where a lay person could read the law and understand what their rights are in terms of getting care, etc.
{Tape: 1; Side: B; Approx. Time Counter: 8.4 - 11.9}

Vote: **Motion carried unanimously by roll call vote 16-0. REP. WINDY BOY voted by proxy.**

REP. MCNUTT will carry the bill.
{Tape: 1; Side: B; Approx. Time Counter: 11.9 - 14.4}

EXECUTIVE ACTION ON SB 33

Motion/Vote: **REP. HENDRICK moved that SB 33 BE CONCURRED IN. Motion carried 15-1 by voice vote with REP. JONES voting no. REP. WINDY BOY voted by proxy.**

REP. MCALPIN will carry the bill.
{Tape: 1; Side: B; Approx. Time Counter: 14.4 - 16.5. REP. MILBURN left the hearing.}

EXECUTIVE ACTION ON SB 46

Motion: **REP. HENRY moved that SB 46 BE CONCURRED IN.**

Discussion:

REP. STOKER said that the ombudsman would now be a source of information in the process under Child Protective Services. As such, she will get from DPHHS the chronological events on complaints.

Ms. Fox explained that this bill came first and then SB 81 was drafted which added the family ombudsman concept on top of the mental health ombudsman. The duties in the second bill confined the new duties related to the child and family ombudsman and to a more narrow scope than the mental health ombudsman. The bills do work mechanically together.

REP. HENRY asked if both bills were needed. **Ms. Fox** said, "Yes."

REP. STOKER said that the ombudsman has been able to be a resource for people so they know where to go to get help. The new duties would be expanded beyond that source of information. The confidentiality of HIPPA was a major concern and this bill had requested written authorization from the client to the ombudsman. If the Committee wants to expand the file information from DPHHS to the ombudsman, this is the bill to pass.
{Tape: 1; Side: B; Approx. Time Counter: 16.5 - 24}

REP. MCGILLVRAY felt that the bureaucracy just keeps growing even though he thought the bill was necessary.

Vote: Motion carried 15-1 by roll call vote with REP. ROBERTS voting no. REP. WINDY BOY and REP. MILBURN voted by proxy.

REP. HENRY will carry the bill.
{Tape: 1; Side: B; Approx. Time Counter: 23.3 - 28.3}

EXECUTIVE ACTION ON SB 154

REP. FACEY asked the Committee to hear the Subcommittee's discussion before taking executive action.

REP. FACEY proposed some amendments.

Ms. Fox explained that the amendments had been proposed by Chuck Hunter, DPHHS, and that at the original hearing, he said they need more work in order to reach a consensus. She read the amendments and explained each one to the Committee.
{Tape: 1; Side: B; Approx. Time Counter: 28.3 - 32; Comments: Ms. Fox continues on Tape: 2; Side A. REP. WINDY BOY and REP. MILBURN return to the hearing.}

REP. CAFERRO supported the amendments.

REP. STOKER felt that the bill micro-managed the Department too much.

REP. CAFERRO replied that Federal law states the administrative costs must be capped at 10%. It does not distinguish between the way CHIP is administered now or if it would be handled by the Department. A letter from Mr. Bilodeau was handed out to the Committee.
EXHIBIT(huh69a07)

REP. MCGILLVRAY felt that staying under 10% was reasonable.

Motion: REP. MCGILLVRAY moved that SB 154 BE CONCURRED IN.

Motion: REP. MCGILLVRAY moved that SB 154 BE AMENDED.
EXHIBIT(huh69a08)

Vote: Motion carried unanimously by roll call vote 16-0.

Motion/Vote: REP. CAFERRO moved that SB 154 BE CONCURRED IN AS AMENDED. Motion carried unanimously by voice vote 16-0.

REP. FACEY will carry the bill.
{Tape: 2; Side: A; Approx. Time Counter: 0 - 10. REP. FACEY left the hearing.}

EXECUTIVE ACTION ON SJ 15

Motion: REP. WAGMAN moved that SJ 15 BE CONCURRED IN.

Motion: REP. MCALPIN moved that SJ 15 BE AMENDED.
EXHIBIT(huh69a09)

Discussion:

REP. MCALPIN explained the amendment. It would change the polybromides to include all rather than separating the DECAs from the OCTAs and PENTAs. This would take off the Senate amendments which had made it more specific to particulars.

Vote: Motion carried 15-1 by voice vote with REP. JONES voting no. REP. FACEY voted by proxy.

REP. WAGMAN spoke about asking for comments from people who had not had the opportunity to speak for or against the bill. He had received an e-mail which he handed out to the Committee. He explained the rate of heat for different materials. The use of flame retardants had become necessary to slow down the rate of burning. If flame retardants are taken out of materials, more fire deaths will result. The best situation would be non-combustible buildings and fill them with non-combustible materials. But he knew that would not happen.
EXHIBIT(huh69a10)

Motion: REP. WAGMAN moved that SJ 15 BE AMENDED.
EXHIBIT(huh69a11)

REP. WAGMAN explained that the amendment targets all the other materials that have been identified as carcinogen and leaves the DECAs.

Ms. Fox also explained the amendments. It eliminates the use of two polybrominated diphenyl ethers (PBDE), the PENTAs and OCTAs that had been spoken about. It also removes one of the "Whereas" clauses.

REP. WARDEN resisted the amendment.

REP. MCALPIN said that this amendment would undo the amendment that had just been passed.

REP. WAGMAN withdrew his amendments without objection.

Motion/Vote: REP. MILBURN moved that SJ 15 BE TABLED. Motion failed 8-8 by roll call vote with REP. HENDRICK, REP. JONES, REP. MCGILLVRAY, REP. MILBURN, REP. ROBERTS, REP. STOKER, REP. WAGMAN, and REP. WARDEN voting aye. REP. FACEY voted by proxy.

Motion/Vote: REP. HENRY moved that SJ 15 BE CONCURRED IN AS AMENDED. Motion failed 8-8 by roll call vote with REP. BECKER, REP. CAFERRO, REP. EATON, REP. FACEY, REP. HENRY, REP. MCALPIN, REP. NOONAN, and REP. WINDY BOY voting aye. REP. FACEY voted by proxy.
{Tape: 2; Side: A; Approx. Time Counter: 10 - 23.8}

EXECUTIVE ACTION ON SB 328

Motion: REP. WINDY BOY moved that SB 328 BE CONCURRED IN.

Motion: REP. HENRY moved that SB 328 BE AMENDED.
EXHIBIT(huh69a12)

{REP. FACEY returned to the hearing.}

Discussion:

REP. HENRY explained that in Section 1, Line 18, add "(f) cervical cancer survivor." On Line 21, after Additional members, delete "with a specific expertise." On Line 25, after cervical cancer, delete the rest of the sentence. On Line 28, after new technologies, delete "including any newly introduced vaccines." She was not necessarily in favor of the amendment on Line 13, (2) add after five members, "not more than 10."

REP. WARDEN asked about the additional members.

CHAIRMAN BECKER said that she felt this task force would be a subdivision of the Montana Comprehensive Cancer Control Planning Group.

REP. MCALPIN had spoken to SEN. SQUIRES and she told him that this group would not do its work to the detriment of the broader group.

REP. HENRY said that she felt it best to leave the number of members at five; otherwise, there could be some doubling up of members.

REP. WINDY BOY asked if there would be people who had specific expertise. **REP. HENRY** said that a member did not have to be a scientist or doctor. They could be a survivor or a general healthcare provider.

REP. HENDRICK wondered why another study group was needed. **REP. HENRY** said there was new information on a vaccination for one of the significant risk factors. Since Montana does not have a great history on immunization, this could be very important to educate women about new ways to handle cervical cancer.

Vote: Motion to amend carried 14-2 by voice vote with REP. JONES and REP. MCGILLVRAY voting no.

Motion: REP. HENRY moved that SB 328 BE CONCURRED IN AS AMENDED.

Discussion:

REP. NOONAN wanted to make a conceptual amendment to put the task force under the Montana Comprehensive Cancer Control Planning Group.

REP. STOKER believed that with a zero fiscal note, a change to put the task force under another group might generate a fiscal note.

REP. MCALPIN said that the funding is a Federal grant with the exception of the services of DPHHS employee, Sue Miller.

Vote: Motion carried 13-3 by voice vote with REP. JONES, REP. MCGILLVRAY, and REP. MILBURN voting no.

REP. BECKER will carry the bill.

ADJOURNMENT

Adjournment: 5:15 P.M.

_____
REP. ARLENE BECKER, Chairman

_____
MARY GAY WELLS, Secretary

AB/mw

Additional Exhibits:

EXHIBIT(huh69aad0.PDF)

EXHIBIT 6
DATE 4-1-05
SB 481

Amendments to Senate Bill No. 481
3rd Reading Copy

Requested by Senator Vicki Cocchiarella

For the House Human Services Committee

Prepared by Pat Murdo
March 23, 2005 (8:14am)

1. Page 22, line 17.
Strike: "more than 50% responsible for"
Insert: "the major contributing cause of"

2. Page 38, line 3.
Insert: "NEW SECTION. **Section 41. Direction to code commissioner.** The code commissioner is directed to change any reference to chapter 72 of Title 39 that appears in legislation enacted by the 2005 legislature to a reference to chapter 71 of Title 39."
Renumber: subsequent sections

- END -

~~(4)~~*(3)* A person is not liable for any severance tax upon 50,000 tons of the coal that the person produces in a calendar year, except that if more than 50,000 tons of coal are produced in a calendar year, the producer is liable for severance tax upon all coal produced in excess of the first 20,000 tons."

Section 2. Effective date. [This act] is effective on passage and approval.

Approved April 25, 2005

CHAPTER NO. 416

[SB 481]

AN ACT MERGING OCCUPATIONAL DISEASES INTO THE WORKERS' COMPENSATION ACT; ESTABLISHING LEGISLATIVE INTENT TOWARD OCCUPATIONAL DISEASES AS PUBLIC POLICY; DEFINING "OCCUPATIONAL DISEASE"; PROVIDING FOR THE LIABILITY OF INSURERS AND COMPENSATION FOR OCCUPATIONAL DISEASES UNDER THE WORKERS' COMPENSATION ACT; PROVIDING FOR TIME FOR CLAIMS TO BE PRESENTED; AMENDING SECTIONS 2-15-2015, 30-9A-109, 37-1-131, 39-71-105, 39-71-106, 39-71-107, 39-71-116, 39-71-201, 39-71-206, 39-71-211, 39-71-315, 39-71-316, 39-71-317, 39-71-403, 39-71-407, 39-71-416, 39-71-525, 39-71-601, 39-71-603, 39-71-612, 39-71-743, 39-71-915, 39-71-1105, 39-71-2401, 39-71-2406, 39-71-2408, 39-71-2411, 39-73-104, 39-73-107, 45-6-301, 71-3-1118, AND 85-5-101, MCA; REPEALING SECTIONS 39-72-101, 39-72-102, 39-72-103, 39-72-201, 39-72-202, 39-72-203, 39-72-204, 39-72-206, 39-72-301, 39-72-302, 39-72-303, 39-72-305, 39-72-310, 39-72-401, 39-72-402, 39-72-403, 39-72-404, 39-72-405, 39-72-408, 39-72-509, 39-72-601, 39-72-602, 39-72-606, 39-72-607, 39-72-608, 39-72-701, 39-72-703, 39-72-704, 39-72-705, 39-72-706, 39-72-707, 39-72-708, 39-72-709, 39-72-711, 39-72-712, AND 39-72-714, MCA; AND PROVIDING AN EFFECTIVE DATE AND AN APPLICABILITY DATE.

Be it enacted by the Legislature of the State of Montana:

Section 1. Applicability of workers' compensation act — exceptions. Except as provided in 39-71-407, 39-71-601, and 39-71-603, this chapter applies to injuries and occupational diseases.

Section 2. Compensation for occupational diseases and medical benefits — diminution of compensation. (1) Compensation for occupational diseases must be equal to the compensation and medical benefits provided for injuries in this chapter.

(2) When the same medical condition may be claimed as an injury and an occupational disease, compensation payable to the claimant, the claimant's beneficiaries, or the claimant's dependents may not be duplicated for the same conditions over the same time period.

Section 3. Autopsy. Upon the filing of a claim for compensation for death caused by an occupational disease, if an autopsy is necessary to determine the cause of death, an autopsy may be requested by an insurer. The autopsy must be made under the supervision of the county coroner or a medical examiner. The expense of the autopsy must be paid by the insurer.

Section 4. Benefits for pneumoconiosis. (1) Pneumoconiosis is an occupational disease that is compensable under this part. However, any benefits granted a claimant under this chapter for pneumoconiosis must be reduced, but

not below zero, by an amount equal to the benefits granted the claimant under any program under federal law that pays benefits for a claimant suffering disability from pneumoconiosis.

(2) "Pneumoconiosis" means a chronic dust disease of the lungs arising out of employment in coal mines and includes anthracosis, coal workers' pneumoconiosis, silicosis, or anthracosilicosis arising out of employment.

Section 5. Prohibiting supplementing of benefits. A person receiving compensation or benefits under chapter 73 of this title is not entitled to compensation or benefits under this chapter.

Section 6. Section 2-15-2015, MCA, is amended to read:

"2-15-2015. Workers' compensation fraud investigation and prosecution office. There is a workers' compensation fraud investigation and prosecution office in the department of justice. The office shall investigate and prosecute cases referred by the state compensation insurance fund or the department of labor and industry on behalf of the uninsured employers' fund. The office is under the supervision and control of the attorney general and consists of:

(1) one or more investigators qualified by education, training, experience, and high professional competence in investigative procedures who shall investigate violations of the provisions of Title 39, ~~chapters~~ *chapter* 71 ~~and 72~~, at the request of the state compensation insurance fund or the department of labor and industry on behalf of the uninsured employers' fund; and

(2) one or more attorneys licensed to practice law in Montana who shall prosecute violations of the provisions of Title 39, ~~chapters~~ *chapter* 71 ~~and 72~~. The attorneys may also assist county attorneys in prosecuting violations of Title 39, ~~chapters~~ *chapter* 71 ~~and 72~~, without charge to the county.

(3) The state compensation insurance fund, the department of labor and industry, and the department of justice shall submit to the legislature for approval one proposed biennial budget for the workers' compensation fraud office. The proposed budget for staffing and related expenses must be based upon the needs of the state compensation insurance fund and the department of labor and industry on behalf of the uninsured employers' fund for investigating and prosecuting workers' compensation fraud."

Section 7. Section 30-9A-109, MCA, is amended to read:

"30-9A-109. Scope. (1) Except as otherwise provided in subsections (3) and (4), this chapter applies to:

(a) any transaction, regardless of its form, that creates a security interest in personal property or fixtures by contract;

(b) an agricultural lien;

(c) a sale of an account, chattel paper, payment intangible, or promissory note;

(d) a consignment;

(e) a security interest arising under 30-2-401, 30-2-505, 30-2-711(3), or 30-2A-508(5), to the extent provided in 30-9A-110; and

(f) a security interest arising under 30-4-208 or 30-5-118.

(2) The application of this chapter to a security interest in a secured obligation is not affected by the fact that the obligation is itself secured by a transaction or interest to which this chapter does not apply.

(3) This chapter does not apply to the extent that:

(a) a statute, regulation, or treaty of the United States preempts this chapter;

(b) another statute of this state expressly governs the creation, perfection, priority, or enforcement of a security interest created by this state or a governmental unit of this state;

(c) a statute of another state, a foreign country, or a governmental unit of another state or a foreign country, other than a statute generally applicable to security interests, expressly governs creation, perfection, priority, or enforcement of a security interest created by the state, country, or governmental unit; or

(d) the rights of a transferee beneficiary or nominated person under a letter of credit are independent and superior under 30-5-134.

(4) This chapter does not apply to:

(a) a landlord's lien, other than an agricultural lien;

(b) a lien, other than an agricultural lien, given by statute or other rule of law for services or materials, but 30-9A-333 applies with respect to priority of the lien;

(c) an assignment of a claim for wages, salary, or other compensation of an employee;

(d) a sale of accounts, chattel paper, payment intangibles, or promissory notes as part of a sale of the business out of which they arose;

(e) an assignment of accounts, chattel paper, payment intangibles, or promissory notes that is for the purpose of collection only;

(f) an assignment of a right to payment under a contract to an assignee that is also obliged to perform under the contract;

(g) an assignment of a single account, payment intangible, or promissory note to an assignee in full or partial satisfaction of a preexisting indebtedness;

(h) a transfer of an interest in or an assignment of a claim under a policy of insurance, other than an assignment by or to a health care provider of a health-care-insurance receivable and any subsequent assignment of the right to payment, but 30-9A-315 and 30-9A-322 apply with respect to proceeds and priorities in proceeds;

(i) an assignment of a right represented by a judgment, other than a judgment taken on a right to payment that was collateral;

(j) a right of recoupment or setoff, but:

(i) 30-9A-340 applies with respect to the effectiveness of rights of recoupment or setoff against deposit accounts; and

(ii) 30-9A-404 applies with respect to defenses or claims of an account debtor;

(k) the creation or transfer of an interest in or lien on real property, including a lease or rents under the interest in real property, except to the extent that provision is made for:

(i) liens on real property in 30-9A-203 and 30-9A-308;

(ii) fixtures in 30-9A-334;

(iii) fixture filings in 30-9A-501, 30-9A-502, 30-9A-512, 30-9A-516, and 30-9A-519; and

(iv) security agreements covering personal and real property in 30-9A-604;

(l) an assignment of a claim arising in tort, other than a commercial tort claim, but 30-9A-315 and 30-9A-322 apply with respect to proceeds and priorities in proceeds;

(m) a transfer by a government or governmental subdivision or agency;

(n) an assignment of a deposit account in a consumer transaction, except that 30-9A-315 and 30-9A-322 apply with respect to proceeds and priorities in proceeds; or

(o) an assignment of payments made to or on behalf of claimants pursuant to Title 39, chapter 51, 71, ~~72,~~ or 73."

Section 8. Section 37-1-131, MCA, is amended to read:

"37-1-131. Duties of boards — quorum required. Each board within the department shall:

(1) set and enforce standards and rules governing the licensing, certification, registration, and conduct of the members of the particular profession or occupation within its jurisdiction;

(2) sit in judgment in hearings for the suspension, revocation, or denial of a license of an actual or potential member of the particular profession or occupation within its jurisdiction. The hearings must be conducted by a hearing examiner when required under 37-1-121(1).

(3) suspend, revoke, or deny a license of a person who the board determines, after a hearing as provided in subsection (2), is guilty of knowingly defrauding, abusing, or aiding in the defrauding or abusing of the workers' compensation system in violation of the provisions of Title 39, chapter 71 ~~or 72~~;

(4) pay to the department its pro rata share of the assessed costs of the department under 37-1-101(6);

(5) consult with the department before the board initiates a program expansion, under existing legislation, to determine if the board has adequate money and appropriation authority to fully pay all costs associated with the proposed program expansion. The board may not expand a program if the board does not have adequate money and appropriation authority available.

(6) A board, board panel, or subcommittee convened to conduct board business must have a majority of its members, which constitutes a quorum, present to conduct business."

Section 9. Section 39-71-105, MCA, is amended to read:

"39-71-105. Declaration of public policy. For the purposes of interpreting and applying Title 39, ~~chapters~~ *chapter* 71 ~~and 72~~, the following is the public policy of this state:

(1) It is an objective of the Montana workers' compensation system to provide, without regard to fault, wage supplement and medical benefits to a worker suffering from a work-related injury or disease. Wage-loss benefits are not intended to make an injured worker whole; they are intended to assist a worker at a reasonable cost to the employer. Within that limitation, the wage-loss benefit should bear a reasonable relationship to actual wages lost as a result of a work-related injury or disease.

(2) A worker's removal from the work force due to a work-related injury or disease has a negative impact on the worker, the worker's family, the employer,

and the general public. Therefore, it is an objective of the workers' compensation system to return a worker to work as soon as possible after the worker has suffered a work-related injury or disease.

(3) Montana's workers' compensation and occupational disease insurance systems are intended to be primarily self-administering. Claimants should be able to speedily obtain benefits, and employers should be able to provide coverage at reasonably constant rates. To meet these objectives, the system must be designed to minimize reliance upon lawyers and the courts to obtain benefits and interpret liabilities.

(4) Title 39, ~~chapters~~ *chapter* 71 ~~and 72~~, must be construed according to ~~their~~ *its* terms and not liberally in favor of any party.

(5) It is the intent of the legislature that:

(a) stress claims, often referred to as "mental-mental claims" and "mental-physical claims", are not compensable under Montana's workers' compensation and occupational disease laws. The legislature recognizes that these claims are difficult to objectively verify and that the claims have a potential to place an economic burden on the workers' compensation and occupational disease system. The legislature also recognizes that there are other states that do not provide compensation for various categories of stress claims and that stress claims have presented economic problems for certain other jurisdictions. In addition, not all injuries are compensable under the present system, as is the case with repetitive injury claims, and it is within the legislature's authority to define the limits of the workers' compensation and occupational disease system.

(b) for occupational disease claims, because of the nature of exposure, workers should not be required to provide notice to employers of the disease as required of injuries and that the requirements for filing of claims reflect consideration of when the worker knew or should have known that the worker's condition resulted from an occupational disease. The legislature recognizes that occupational diseases in the workplace are caused by events occurring on more than a single day or work shift and that it is within the legislature's authority to define an occupational disease and establish the causal connection to the workplace."

Section 10. Section 39-71-106, MCA, is amended to read:

"39-71-106. No liability for reporting violation. A person, including but not limited to an insurer or an employer, may not be held liable for civil damages as a result of reporting in good faith information that the person believes proves a violation of the provisions of ~~chapter 72 or~~ this chapter."

Section 11. Section 39-71-107, MCA, is amended to read:

"39-71-107. Insurers to act promptly on claims — in-state adjusters. (1) Pursuant to the public policy stated in 39-71-105, prompt claims handling practices are necessary to provide appropriate service to injured workers, to employers, and to providers who are the customers of the workers' compensation system.

(2) All workers' compensation and occupational disease claims filed pursuant to the Workers' Compensation Act ~~and the Occupational Disease Act of Montana~~ must be adjusted by a person in Montana. For a claim to be considered as adjusted by a person in Montana, the person adjusting the claim is required to determine the entitlement to benefits, authorize payment of all benefits due, manage the claim, have authority to settle the claim, maintain an

office located in Montana, and adjust Montana claims from that office. Use of a mailbox or maildrop in Montana does not constitute maintaining an office in Montana.

(3) An insurer shall maintain the documents related to each claim filed with the insurer under the Workers' Compensation Act ~~and the Occupational Disease Act of Montana~~ at the Montana office of the person adjusting the claim in Montana until the claim is settled. The documents may be either original documents or duplicates of the original documents and must be maintained in a manner that allows the documents to be retrieved from that office and copied at the request of the claimant or the department. Settled claim files stored outside of the adjuster's office must be made available within 48 hours of a request for the file. Electronic or optically imaged documents are permitted.

(4) An insurer shall provide to the claimant:

(a) a written statement of the reasons that a claim is being denied at the time of denial;

(b) whenever benefits requested by a claimant are denied, a written explanation of how the claimant may appeal an insurer's decision; and

(c) a written explanation of the amount of wage loss benefits being paid to the claimant, along with an explanation of the calculation used to compute those benefits. The explanation must be sent within 7 days of the initial payment of the benefit.

(5) An insurer shall:

(a) begin making payments that are due on a claim within 14 days of acceptance of the claim, unless the insurer promptly notifies the claimant that the insurer needs additional information in order to begin paying benefits and specifies the information needed; and

(b) pay settlements within 30 days of the date the department issues an order approving the settlement.

(6) An insurer may not make payments pursuant to 39-71-608 or any other reservation of rights for more than 90 days without:

(a) written consent of the claimant; or

(b) approval of the department.

(7) The department may adopt rules to implement this section.

(8) *(a)* For purposes of this section, "settled claim" means a department-approved or court-ordered compromise of benefits between a claimant and an insurer or a claim that was paid in full.

(b) The term does not include a claim in which there has been only a lump-sum advance of benefits."

Section 12. Section 39-71-116, MCA, is amended to read:

"39-71-116. Definitions. Unless the context otherwise requires, in this chapter, the following definitions apply:

(1) "Actual wage loss" means that the wages that a worker earns or is qualified to earn after the worker reaches maximum healing are less than the actual wages the worker received at the time of the injury.

(2) "Administer and pay" includes all actions by the state fund under the Workers' Compensation Act ~~and the Occupational Disease Act of Montana~~ necessary to:

(a) investigation, review, and settlement of claims;

(b) payment of benefits;

(c) setting of reserves;

(d) furnishing of services and facilities; and

(e) use of actuarial, audit, accounting, vocational rehabilitation, and legal services.

(3) "Aid or sustenance" means a public or private subsidy made to provide a means of support, maintenance, or subsistence for the recipient.

(4) "Average weekly wage" means the mean weekly earnings of all employees under covered employment, as defined and established annually by the department. It is established at the nearest whole dollar number and must be adopted by the department before July 1 of each year.

(5) "Beneficiary" means:

(a) a surviving spouse living with or legally entitled to be supported by the deceased at the time of injury;

(b) an unmarried child under 18 years of age;

(c) an unmarried child under 22 years of age who is a full-time student in an accredited school or is enrolled in an accredited apprenticeship program;

(d) an invalid child over 18 years of age who is dependent, as defined in 26 U.S.C. 152, upon the decedent for support at the time of injury;

(e) a parent who is dependent, as defined in 26 U.S.C. 152, upon the decedent for support at the time of the injury if a beneficiary, as defined in subsections (5)(a) through (5)(d), does not exist; and

(f) a brother or sister under 18 years of age if dependent, as defined in 26 U.S.C. 152, upon the decedent for support at the time of the injury but only until the age of 18 years and only when a beneficiary, as defined in subsections (5)(a) through (5)(e), does not exist.

(6) "Business partner" means the community, governmental entity, or business organization that provides the premises for work-based learning activities for students.

(7) "Casual employment" means employment not in the usual course of the trade, business, profession, or occupation of the employer.

(8) "Child" includes a posthumous child, a dependent stepchild, and a child legally adopted prior to the injury.

(9) "Construction industry" means the major group of general contractors and operative builders, heavy construction (other than building construction) contractors, and special trade contractors listed in major group 23 in the North American Industry Classification System Manual. The term does not include office workers, design professionals, salespersons, estimators, or any other related employment that is not directly involved on a regular basis in the provision of physical labor at a construction or renovation site.

(10) "Days" means calendar days, unless otherwise specified.

(11) "Department" means the department of labor and industry.

(12) "Fiscal year" means the period of time between July 1 and the succeeding June 30.

(13) "Household or domestic employment" means employment of persons other than members of the household for the purpose of tending to the aid and comfort of the employer or members of the employer's family, including but not limited to housecleaning and yard work, but does not include employment beyond the scope of normal household or domestic duties, such as home health care or domiciliary care.

(14) "Insurer" means an employer bound by compensation plan No. 1, an insurance company transacting business under compensation plan No. 2, or the state fund under compensation plan No. 3.

(15) "Invalid" means one who is physically or mentally incapacitated.

(16) "Limited liability company" is as defined in 35-8-102.

(17) "Maintenance care" means treatment designed to provide the optimum state of health while minimizing recurrence of the clinical status.

(18) "Medical stability", "maximum healing", or "maximum medical healing" means a point in the healing process when further material improvement would not be reasonably expected from primary medical treatment.

(19) "Objective medical findings" means medical evidence, including range of motion, atrophy, muscle strength, muscle spasm, or other diagnostic evidence, substantiated by clinical findings.

(20) (a) "Occupational disease" means harm, damage, or death arising out of or contracted in the course and scope of employment caused by events occurring on more than a single day or work shift.

(b) The term does not include a physical or mental condition arising from emotional or mental stress or from a nonphysical stimulus or activity.

~~(20)~~*(21)* "Order" means any decision, rule, direction, requirement, or standard of the department or any other determination arrived at or decision made by the department.

~~(21)~~*(22)* "Palliative care" means treatment designed to reduce or ease symptoms without curing the underlying cause of the symptoms.

~~(22)~~*(23)* "Payroll", "annual payroll", or "annual payroll for the preceding year" means the average annual payroll of the employer for the preceding calendar year or, if the employer has not operated a sufficient or any length of time during the calendar year, 12 times the average monthly payroll for the current year. However, an estimate may be made by the department for any employer starting in business if average payrolls are not available. This estimate must be adjusted by additional payment by the employer or refund by the department, as the case may actually be, on December 31 of the current year. An employer's payroll must be computed by calculating all wages, as defined in 39-71-123, that are paid by an employer.

~~(23)~~*(24)* "Permanent partial disability" means a physical condition in which a worker, after reaching maximum medical healing:

(a) has a permanent impairment established by objective medical findings;

(b) is able to return to work in some capacity but the permanent impairment impairs the worker's ability to work; and

(c) has an actual wage loss as a result of the injury.

~~(24)~~*(25)* "Permanent total disability" means a physical condition resulting from injury as defined in this chapter, after a worker reaches maximum medical

healing, in which a worker does not have a reasonable prospect of physically performing regular employment. Regular employment means work on a recurring basis performed for remuneration in a trade, business, profession, or other occupation in this state. Lack of immediate job openings is not a factor to be considered in determining if a worker is permanently totally disabled.

~~(25)~~*(26)* The "plant of the employer" includes the place of business of a third person while the employer has access to or control over the place of business for the purpose of carrying on the employer's usual trade, business, or occupation.

~~(26)~~*(27)* "Primary medical services" means treatment prescribed by a treating physician, for conditions resulting from the injury, necessary for achieving medical stability.

~~(27)~~*(28)* "Public corporation" means the state or a county, municipal corporation, school district, city, city under a commission form of government or special charter, town, or village.

~~(28)~~*(29)* "Reasonably safe place to work" means that the place of employment has been made as free from danger to the life or safety of the employee as the nature of the employment will reasonably permit.

~~(29)~~*(30)* "Reasonably safe tools and appliances" are tools and appliances that are adapted to and that are reasonably safe for use for the particular purpose for which they are furnished.

~~(30)~~*(31)* (a) "Secondary medical services" means those medical services or appliances that are considered not medically necessary for medical stability. The services and appliances include but are not limited to spas or hot tubs, work hardening, physical restoration programs and other restoration programs designed to address disability and not impairment, or equipment offered by individuals, clinics, groups, hospitals, or rehabilitation facilities.

(b) (i) As used in this subsection ~~(30)~~ *(31)*, "disability" means a condition in which a worker's ability to engage in gainful employment is diminished as a result of physical restrictions resulting from an injury. The restrictions may be combined with factors, such as the worker's age, education, work history, and other factors that affect the worker's ability to engage in gainful employment.

(ii) Disability does not mean a purely medical condition.

~~(31)~~*(32)* "Sole proprietor" means the person who has the exclusive legal right or title to or ownership of a business enterprise.

~~(32)~~*(33)* "Temporary partial disability" means a physical condition resulting from an injury, as defined in 39-71-119, in which a worker, prior to maximum healing:

(a) is temporarily unable to return to the position held at the time of injury because of a medically determined physical restriction;

(b) returns to work in a modified or alternative employment; and

(c) suffers a partial wage loss.

~~(33)~~*(34)* "Temporary service contractor" means a person, firm, association, partnership, limited liability company, or corporation conducting business that hires its own employees and assigns them to clients to fill a work assignment with a finite ending date to support or supplement the client's workforce in situations resulting from employee absences, skill shortages, seasonal workloads, and special assignments and projects.

~~(34)~~*(35)* "Temporary total disability" means a physical condition resulting from an injury, as defined in this chapter, that results in total loss of wages and exists until the injured worker reaches maximum medical healing.

~~(35)~~*(36)* "Temporary worker" means a worker whose services are furnished to another on a part-time or temporary basis to fill a work assignment with a finite ending date to support or supplement a workforce in situations resulting from employee absences, skill shortages, seasonal workloads, and special assignments and projects.

~~(36)~~*(37)* "Treating physician" means a person who is primarily responsible for the treatment of a worker's compensable injury and is:

(a) a physician licensed by the state of Montana under Title 37, chapter 3, and has admitting privileges to practice in one or more hospitals, if any, in the area where the physician is located;

(b) a chiropractor licensed by the state of Montana under Title 37, chapter 12;

(c) a physician assistant-certified licensed by the state of Montana under Title 37, chapter 20, if there is not a treating physician, as provided for in subsection ~~(36)(a)~~ *(37)(a)*, in the area where the physician assistant-certified is located;

(d) an osteopath licensed by the state of Montana under Title 37, chapter 3;

(e) a dentist licensed by the state of Montana under Title 37, chapter 4;

(f) for a claimant residing out of state or upon approval of the insurer, a treating physician defined in subsections ~~(36)(a)~~ *(37)(a)* through ~~(36)(e)~~ *(37)(e)* who is licensed or certified in another state; or

(g) an advanced practice registered nurse licensed by the state of Montana under Title 37, chapter 8, recognized by the board of nursing as a nurse practitioner or a clinical nurse specialist, and practicing in consultation with a physician licensed under Title 37, chapter 3, if there is not a treating physician, as provided for in subsection ~~(36)(a)~~ *(37)(a)*, in the area in which the advanced practice registered nurse is located.

~~(37)~~*(38)* "Work-based learning activities" means job training and work experience conducted on the premises of a business partner as a component of school-based learning activities authorized by an elementary, secondary, or postsecondary educational institution.

~~(38)~~*(39)* "Year", unless otherwise specified, means calendar year."

Section 13. Section 39-71-201, MCA, is amended to read:

"39-71-201. Administration fund. (1) A workers' compensation administration fund is established out of which all costs of administering the Workers' Compensation ~~and Occupational Disease Acts~~ *Act* and the statutory occupational safety acts *that* the department is required to administer, with the exception of the subsequent injury fund, as provided for in 39-71-907, and the uninsured employers' fund, are to be paid upon lawful appropriation. The department shall collect and deposit in the state treasury to the credit of the workers' compensation administration fund:

(a) all fees and penalties provided in 39-71-205, 39-71-223, 39-71-304, 39-71-307, 39-71-308, 39-71-315, 39-71-316, 39-71-401(6), 39-71-2204, 39-71-2205, and 39-71-2337; and

(b) all fees paid by an assessment of 3% of paid losses, plus administrative fines and interest provided by this section.

(2) For the purposes of this section, paid losses include the following benefits paid during the preceding calendar year for injuries covered by the Workers' Compensation Act ~~and the Occupational Disease Act of Montana~~ without regard to the application of any deductible whether the employer or the insurer pays the losses:

(a) total compensation benefits paid; and

(b) except for medical benefits in excess of $200,000 for each occurrence that are exempt from assessment, total medical benefits paid for medical treatment rendered to an injured worker, including hospital treatment and prescription drugs.

(3) Each plan No. 1 employer, plan No. 2 insurer subject to the provisions of this section, and plan No. 3, the state fund, shall file annually on March 1 in the form and containing the information required by the department a report of paid losses pursuant to subsection (2).

(4) Each employer enrolled under compensation plan No. 1, compensation plan No. 2, or compensation plan No. 3, the state fund, shall pay a proportionate share of all costs of administering and regulating the Workers' Compensation Act ~~and the Occupational Disease Act of Montana~~ and the statutory occupational safety acts that the department is required to administer, with the exception of the subsequent injury fund, as provided for in 39-71-907, and the uninsured employers' fund. In addition, compensation plan No. 3, the state fund, shall pay a proportionate share of these costs based upon paid losses for claims arising before July 1, 1990.

(5) (a) Each employer enrolled under compensation plan No. 1 shall pay an assessment to fund administrative and regulatory costs. The assessment is equal to 3% of the paid losses paid in the preceding calendar year by or on behalf of the plan No. 1 employer or $500, whichever is greater. Any entity, other than the department, that assumes the obligations of an employer enrolled under compensation plan No. 1 is considered to be the employer for the purposes of this section.

(b) An employer formerly enrolled under compensation plan No. 1 shall pay an assessment to fund administrative and regulatory costs. The assessment is equal to 3% of the paid losses paid in the preceding calendar year by or on behalf of the employer for claims arising out of the time when the employer was enrolled under compensation plan No. 1.

(c) Payment of the assessment provided for by this subsection (5) must be paid by the employer in:

(i) one installment due on July 1; or

(ii) two equal installments due on July 1 and December 31 of each year.

(d) If an employer fails to timely pay to the department the assessment under this section, the department may impose on the employer an administrative fine of $500 plus interest on the delinquent amount at the annual interest rate of 12%. Administrative fines and interest must be deposited in the workers' compensation administration fund.

(6) (a) Compensation plan No. 3, the state fund, shall pay an assessment to fund administrative and regulatory costs attributable to claims arising before July 1, 1990. The assessment is equal to 3% of the paid losses paid in the

preceding calendar year for claims arising before July 1, 1990. As required by 39-71-2352, the state fund may not pass along to insured employers the cost of the assessment for administrative and regulatory costs that is attributable to claims arising before July 1, 1990.

(b) Payment of the assessment must be paid in:

(i) one installment due on July 1; or

(ii) two equal installments due on July 1 and December 31 of each year.

(c) If the state fund fails to timely pay to the department the assessment under this section, the department may impose on the state fund an administrative fine of $500 plus interest on the delinquent amount at the annual interest rate of 12%. Administrative fines and interest must be deposited in the workers' compensation administration fund.

(7) (a) Each employer insured under compensation plan No. 2 or plan No. 3, the state fund, shall pay a premium surcharge to fund administrative and regulatory costs. The premium surcharge must be collected by each plan No. 2 insurer and by plan No. 3, the state fund, from each employer that it insures. The premium surcharge must be stated as a separate cost on an insured employer's policy or on a separate document submitted to the insured employer and must be identified as "workers' compensation regulatory assessment surcharge". The premium surcharge must be excluded from the definition of premiums for all purposes, including computation of insurance producers' commissions or premium taxes. However, an insurer may cancel a workers' compensation policy for nonpayment of the premium surcharge. When collected, assessments may not constitute an element of loss for the purpose of establishing rates for workers' compensation insurance but, for the purpose of collection, must be treated as a separate cost imposed upon insured employers.

(b) The amount to be funded by the premium surcharge is equal to 3% of the paid losses paid in the preceding calendar year by or on behalf of all plan No. 2 insurers and 3% of paid losses for claims arising on or after July 1, 1990, for plan No. 3, the state fund, plus or minus any adjustments as provided by subsection (7)(f). The amount to be funded must be divided by the total premium paid by all employers enrolled under compensation plan No. 2 or plan No. 3 during the preceding calendar year. A single premium surcharge rate, applicable to all employers enrolled in compensation plan No. 2 or plan No. 3, must be calculated annually by the department by not later than April 30. The resulting rate, expressed as a percentage, is levied against the premium paid by each employer enrolled under compensation plan No. 2 or plan No. 3 in the next fiscal year.

(c) On or before April 30, 2001, and on each succeeding April 30, the department, in consultation with the advisory organization designated pursuant to 33-16-1023, shall notify plan No. 2 insurers and plan No. 3, the state fund, of the premium surcharge percentage to be effective for policies written or renewed annually on and after July 1 of that year.

(d) The premium surcharge must be paid whenever the employer pays a premium to the insurer. Each insurer shall collect the premium surcharge levied against every employer that it insures. Each insurer shall pay to the department all money collected as a premium surcharge within 20 days of the end of the calendar quarter in which the money was collected. If an insurer fails to timely pay to the department the premium surcharge collected under this section, the department may impose on the insurer an administrative fine of $500 plus interest on the delinquent amount at the annual interest rate of 12%.

Administrative fines and interest must be deposited in the workers' compensation administration fund.

(e) If an employer fails to remit to an insurer the total amount due for the premium and premium surcharge, the amount received by the insurer must be applied to the premium surcharge first and the remaining amount applied to the premium due.

(f) The amount actually collected as a premium surcharge in a given year must be compared to the 3% of paid losses paid in the preceding year. Any amount collected in excess of the 3% must be deducted from the amount to be collected as a premium surcharge in the following year. The amount collected that is less than the 3% must be added to the amount to be collected as a premium surcharge in the following year.

(8) On or before April 30~~, 2001, and on~~ *of* each ~~succeeding April 30~~ *year*, upon a determination by the department, an insurer under compensation plan No. 2 that pays benefits in the preceding calendar year but that will not collect any premium for coverage in the following fiscal year shall pay an assessment equal to 3% of paid losses paid in the preceding calendar year, subject to a minimum assessment of $500, that is due on July 1.

(9) An employer that makes a first-time application for permission to enroll under compensation plan No. 1 shall pay an assessment of $500 within 15 days of being granted permission by the department to enroll under compensation plan No. 1.

(10) The department shall deposit all funds received pursuant to this section in the state treasury, as provided in this section.

(11) The administration fund must be debited with expenses incurred by the department in the general administration of the provisions of this chapter, including the salaries of its members, officers, and employees and the travel expenses of the members, officers, and employees, as provided for in 2-18-501 through 2-18-503, incurred while on the business of the department either within or without the state.

(12) Disbursements from the administration money must be made after being approved by the department upon claim for disbursement.

(13) The department may assess and collect the workers' compensation regulatory assessment surcharge from uninsured employers, as defined in 39-71-501, that fail to properly comply with the coverage requirements of the Workers' Compensation Act ~~and the Occupational Disease Act of Montana~~. Any amounts collected by the department pursuant to this subsection must be deposited in the workers' compensation administration fund."

Section 14. Section 39-71-206, MCA, is amended to read:

"39-71-206. Legal advisers of department and state fund — investigative and prosecution services. (1) The attorney general is the legal adviser of the department and the state fund and shall represent either entity in all proceedings if requested by the department or state fund. The department and state fund may employ other attorneys or legal advisers as they consider necessary.

(2) As provided in 2-15-2015, the attorney general shall provide investigative and prosecution services to the state fund with respect to violations of ~~Title 39, chapters~~ *this chapter* ~~71 and 72~~."

Section 15. Section 39-71-211, MCA, is amended to read:

"39-71-211. Fraud detection and prevention unit — expenditure accounting. (1) The state fund shall establish a fraud prevention and detection unit. The unit is responsible for developing detection and prevention procedures, providing detection services, and providing training in the prevention and detection of fraudulent conduct under Title 39, ~~chapters~~ *chapter* 71 ~~and 72~~, that is subject to prosecution under Title 45. The unit shall refer all cases of suspected fraudulent conduct to the workers' compensation fraud investigation and prosecution office established in 2-15-2015.

(2) The state fund shall expend money to investigate fraud pursuant to this section and shall separately account for money expended."

Section 16. Section 39-71-315, MCA, is amended to read:

"39-71-315. Prohibited actions — penalty. (1) The following actions by a medical provider constitute violations and are subject to the penalty in subsection (2):

(a) failing to document, under oath, the provision of the services or treatment for which compensation is claimed under ~~chapter 72 or~~ this chapter; or

(b) referring a worker for treatment or diagnosis of an injury or illness that is compensable under ~~chapter 72 or~~ this chapter to a facility owned wholly or in part by the provider, unless the provider informs the worker of the ownership interest and provides the name and address of alternate facilities, if any exist.

(2) A person who violates this section may be assessed a penalty of not less than $200 or more than $500 for each offense. The department shall assess and collect the penalty. Penalties collected pursuant to this section must be paid into the state general fund. The workers' compensation court has jurisdiction over actions brought to collect the penalty and over disputes concerning the penalty assessment. Disputes brought pursuant to this section are not subject to mediation.

(3) Subsection (1)(b) does not apply to medical services provided to an injured worker by a treating physician with an ownership interest in a managed care organization that has been certified by the department."

Section 17. Section 39-71-316, MCA, is amended to read:

"39-71-316. Filing true claim — obtaining benefits through deception or other fraudulent means. (1) A person filing a claim under ~~chapter 72 or~~ this chapter, by signing the claim, affirms the information filed is true and correct to the best of that person's knowledge.

(2) (a) A person who obtains or assists in obtaining benefits to which the person is not entitled or who obtains or assists another person in obtaining benefits to which the other person is not entitled under ~~chapter 72 or~~ this chapter is guilty of theft and may be prosecuted under 45-6-301. A county attorney or the attorney general may initiate criminal proceedings against the person. This subsection includes but is not limited to a person who is receiving temporary total disability benefits, permanent total disability benefits, or rehabilitation benefits while working without the knowledge and concurrence of the insurer.

(b) As used in subsection (2)(a), "person" includes but is not limited to an employee, employer, insurer, or medical service provider.

(3) (a) The department may require a person convicted of theft under 45-6-301(5) to pay to the department an amount equal to 10 times the amount

paid by an insurer on the false claim, provided that the amount does not exceed $50,000. If upon demand of the department the person refuses to pay the fine, the department may petition the workers' compensation court to collect the money owed.

(b) The department shall:

(i) use the money collected pursuant to subsection (3)(a) to administer and enforce the provisions of this section; and

(ii) forward any surplus money to the department of justice. The forwarded money must be used exclusively for the staffing and operation of the workers' compensation fraud investigation and prosecution office established in 2-15-2015.

(c) This section does not limit an insurer's civil remedies to collect for money paid to a person convicted under 45-6-301(5).

(4) A person licensed under the provisions of Title 37 is subject to suspension, revocation, or denial of a license if the person knowingly claims or assists in the claiming of benefits in violation of the provisions of ~~chapter 72 or~~ this chapter."

Section 18. Section 39-71-317, MCA, is amended to read:

"39-71-317. Employer not to terminate worker for filing claim — preference — jurisdiction over dispute. (1) An employer may not use as grounds for terminating a worker the filing of a claim under ~~chapter 72 or~~ this chapter. The district court has exclusive jurisdiction over disputes concerning the grounds for termination under this section.

(2) When an injured worker is capable of returning to work within 2 years from the date of injury and has received a medical release to return to work, the worker must be given a preference over other applicants for a comparable position that becomes vacant if the position is consistent with the worker's physical condition and vocational abilities.

(3) This preference applies only to employment with the employer for whom the employee was working at the time the injury occurred.

(4) The workers' compensation court has exclusive jurisdiction to administer or resolve a dispute concerning the reemployment preference under this section. A dispute concerning the reemployment preference is not subject to mediation or a contested case hearing."

Section 19. Section 39-71-403, MCA, is amended to read:

"39-71-403. Plan three exclusive for state agencies — election of plan by public corporations — financing of self-insurance fund — exemption for university system — definition. (1) Except as provided in subsection (5), if a state agency is the employer, the terms, conditions, and provisions of compensation plan No. 3, state fund, are exclusive, compulsory, and obligatory upon both employer and employee. Any sums necessary to be paid under the provisions of this chapter by a state agency are considered to be ordinary and necessary expenses of the agency. The agency shall ~~make appropriation of and~~ pay the sums into the state fund at the time and in the manner provided for in this chapter, notwithstanding that the state agency may have failed to anticipate the ordinary and necessary expense in a budget, estimate of expenses, appropriations, ordinances, or otherwise.

(2) A public corporation, other than a state agency, may elect coverage under compensation plan No. 1, plan No. 2, or plan No. 3, separately or jointly with any

other public corporation, other than a state agency. A public corporation electing compensation plan No. 1 may purchase reinsurance or issue bonds or notes pursuant to subsection (3)(b). A public corporation electing compensation plan No. 1 is subject to the same provisions as a private employer electing compensation plan No. 1.

(3) (a) A public corporation, other than a state agency, that elects plan No. 1 may establish a fund sufficient to pay the compensation and benefits provided for in ~~chapter 72 and~~ this chapter and to discharge all liabilities that are reasonably incurred during the fiscal year for which the election is effective. Proceeds from the fund must be used only to pay claims covered by ~~chapter 72 and~~ this chapter and for actual and necessary expenses required for the efficient administration of the fund, including debt service on any bonds and notes issued pursuant to subsection (3)(b).

(b) (i) A public corporation, other than a state agency, separately or jointly with another public corporation, other than a state agency, may issue and sell its bonds and notes for the purpose of establishing, in whole or in part, the self-insurance workers' compensation fund provided for in subsection (3)(a) and to pay the costs associated with the sale and issuance of the bonds. Bonds and notes may be issued in an amount not exceeding 0.18% of the total assessed value of taxable property, determined as provided in 15-8-111, of the public corporation as of the date of issue. The bonds and notes must be authorized by resolution of the governing body of the public corporation and are payable from an annual property tax levied in the amount necessary to pay principal and interest on the bonds or notes. This authority to levy an annual property tax exists despite any provision of law or maximum levy limitation, including 15-10-420, to the contrary. The revenue derived from the sale of the bonds and notes may not be used for any other purpose.

(ii) The bonds and notes:

(A) may be sold at public or private sale;

(B) do not constitute debt within the meaning of any statutory debt limitation; and

(C) may contain other terms and provisions that the governing body determines.

(iii) Two or more public corporations, other than state agencies, may agree to exercise their respective borrowing powers jointly under this subsection (3)(b) or may authorize a joint board to exercise the powers on their behalf.

(iv) The fund established from the proceeds of bonds and notes issued and sold under this subsection (3)(b) may, if sufficient, be used in lieu of a surety bond, reinsurance, specific and aggregate excess insurance, or any other form of additional security necessary to demonstrate the public corporation's ability to discharge all liabilities as provided in subsection (3)(a). Subject to the total assessed value limitation in subsection (3)(b)(i), a public corporation may issue bonds and notes to establish a fund sufficient to discharge liabilities for periods greater than 1 year.

(4) All money in the fund established under subsection (3)(a) not needed to meet immediate expenditures must be invested by the governing body of the public corporation or the joint board created by two or more public corporations as provided in subsection (3)(b)(iii), and all proceeds of the investment must be credited to the fund.

(5) The provisions of subsection (1) do not apply to the Montana university system.

(6) As used in subsections (2) through (4), "public corporation" includes the Montana university system."

Section 20. Section 39-71-407, MCA, is amended to read:

"39-71-407. Liability of insurers — limitations. (1) ~~Each~~ *For workers' compensation injuries, each* insurer is liable for the payment of compensation, in the manner and to the extent provided in this section, to an employee of an employer *covered under plan No. 1, plan No. 2, and the state fund under plan No. 3* that it insures who receives an injury arising out of and in the course of employment or, in the case of death from the injury, to the employee's beneficiaries, if any.

(2) (a) An insurer is liable for an injury, as defined in 39-71-119, if the injury is established by objective medical findings and if the claimant establishes that it is more probable than not that:

(i) a claimed injury has occurred; or

(ii) a claimed injury aggravated a preexisting condition.

(b) Proof that it was medically possible that a claimed injury occurred or that the claimed injury aggravated a preexisting condition is not sufficient to establish liability.

(3) (a) An employee who suffers an injury or dies while traveling is not covered by this chapter unless:

(i) the employer furnishes the transportation or the employee receives reimbursement from the employer for costs of travel, gas, oil, or lodging as a part of the employee's benefits or employment agreement and the travel is necessitated by and on behalf of the employer as an integral part or condition of the employment; or

(ii) the travel is required by the employer as part of the employee's job duties.

(b) A payment made to an employee under a collective bargaining agreement, personnel policy manual, or employee handbook or any other document provided to the employee that is not wages but is designated as an incentive to work at a particular jobsite is not a reimbursement for the costs of travel, gas, oil, or lodging, and the employee is not covered under this chapter while traveling.

(4) An employee is not eligible for benefits otherwise payable under this chapter if the employee's use of alcohol or drugs not prescribed by a physician is the major contributing cause of the accident. However, if the employer had knowledge of and failed to attempt to stop the employee's use of alcohol or drugs, this subsection does not apply.

(5) If a claimant who has reached maximum healing suffers a subsequent nonwork-related injury to the same part of the body, the workers' compensation insurer is not liable for any compensation or medical benefits caused by the subsequent nonwork-related injury.

(6) An employee is not eligible for benefits payable under this chapter unless the entitlement to benefits is established by objective medical findings that contain sufficient factual and historical information concerning the relationship of the worker's condition to the original injury.

(7) For occupational diseases, every employer enrolled under plan No. 1, every insurer under plan No. 2, or the state fund under plan No. 3 is liable for the payment of compensation, in the manner and to the extent provided in this chapter, to an employee of an employer covered under plan No. 1, plan No. 2, or the state fund under plan No. 3 with an occupational disease that arises out of or is contracted in the course and scope of employment.

(8) Occupational diseases are considered to arise out of employment or be contracted in the course and scope of employment if:

(a) the occupational disease is established by objective medical findings; and

(b) the events occurring on more than a single day or work shift are the major contributing cause of the occupational disease in relation to other factors contributing to the occupational disease.

(9) When compensation is payable for an occupational disease, the only employer liable is the employer in whose employment the employee was last injuriously exposed to the hazard of the disease.

(10) When there is more than one insurer and only one employer at the time that the employee was injuriously exposed to the hazard of the disease, the liability rests with the insurer providing coverage at the earlier of:

(a) the time that the occupational disease was first diagnosed by a treating physician or medical panel; or

(b) the time that the employee knew or should have known that the condition was the result of an occupational disease.

(11) In the case of pneumoconiosis, any coal mine operator who has acquired a mine in the state or substantially all of the assets of a mine from a person who was an operator of the mine on or after December 30, 1969, is liable for and shall secure the payment of all benefits that would have been payable by that person with respect to miners previously employed in the mine if acquisition had not occurred and that person had continued to operate the mine, and the prior operator of the mine is not relieved of any liability under this section.

~~(7)~~*(12)* As used in this section, "major contributing cause" means a cause that is the leading cause contributing to the result when compared to all other contributing causes."

Section 21. Section 39-71-416, MCA, is amended to read:

"39-71-416. Benefit reduction for third-party recovery. (1) If an employee is injured or dies and obtains a third-party recovery, settlement, or award, an insurer may reduce by 30% the benefits paid or that are required to be paid to the employee or beneficiary pursuant to *this* chapter ~~71 or 72~~ as a result of the injury or death. The reduction applies to any recovery, settlement, or award regardless of the form of action or the nature of damages. The total of any reductions may not exceed 30% of any third-party recovery, settlement, or award.

(2) This section does not limit or prohibit an insurer's right to pursue subrogation pursuant to 39-71-414.

(3) If an insurer is entitled to subrogation pursuant to 39-71-414, the amount subrogated must be offset by any reduction in benefits pursuant to subsection (1)."

Section 22. Section 39-71-525, MCA, is amended to read:

"39-71-525. Confidentiality of records — exception for use by public employees. Information obtained from any individual under this part is confidential and may not be disclosed, sold, or opened to public inspection except to department employees when necessary to allow them to perform their public duties under Title 39, ~~chapters~~ *chapter* 71 ~~and 72~~, or to provide relevant and necessary information to other public entities or pursuant to a subpoena issued upon a showing of compelling state interest."

Section 23. Section 39-71-601, MCA, is amended to read:

"39-71-601. Statute of limitation on presentment of claim — waiver. (1) ~~In case of personal injury or death~~ *Except for a claim for benefits for occupational diseases pursuant to subsections (3) and (4),* all claims *in the case of personal injury or death* must be forever barred unless signed by the claimant or the claimant's representative and presented in writing to the employer, the insurer, or the department, as the case may be, within 12 months from the date of the happening of the accident, either by the claimant or someone legally authorized to act on the claimant's behalf.

(2) The insurer may waive the time requirement up to an additional 24 months upon a reasonable showing by the claimant of:

(a) lack of knowledge of disability;

(b) latent injury; or

(c) equitable estoppel.

(3) When a claimant seeks benefits for an occupational disease, the claimant's claims for benefits must be presented in writing to the employer, the employer's insurer, or the department within 1 year from the date that the claimant knew or should have known that the claimant's condition resulted from an occupational disease. When a beneficiary seeks benefits under this chapter, claims for death benefits must be presented in writing to the employer, the employer's insurer, or the department within 1 year from the date that the beneficiary knew or should have known that the decedent's death was related to an occupational disease.

~~(3)~~*(4)* Any dispute regarding the statute of limitations for filing time is considered a dispute that, after mediation pursuant to department rules, is subject to jurisdiction of the workers' compensation court."

Section 24. Section 39-71-603, MCA, is amended to read:

"39-71-603. Notice of injuries other than death to be submitted within thirty days — *exception.* (1) A claim to recover benefits under the Workers' Compensation Act for injuries not resulting in death may not be considered compensable unless, within 30 days after the occurrence of the accident that is claimed to have caused the injury, notice of the time and place where the accident occurred and the nature of the injury is given to the employer or the employer's insurer by the injured employee or someone on the employee's behalf. Actual knowledge of the accident and injury on the part of the employer or the employer's managing agent or superintendent in charge of the work in which the injured employee was engaged at the time of the injury is equivalent to notice.

(2) If a sole proprietor, partner, manager of a manager-managed limited liability company, member of a member-managed limited liability company, or corporate officer covered under this chapter is injured in an accident, the sole proprietor, partner, manager, member, or corporate officer or an appointed

designee shall, within 30 days, notify the insurer of the time and location of the accident and the nature of the injury.

(3) This section does not apply to occupational diseases."

Section 25. Section 39-71-612, MCA, is amended to read:

"**39-71-612. Costs and attorney fees that may be assessed against insurer by workers' compensation judge — barring of attorney fees under common fund or other doctrines.** (1) If an insurer pays or submits a written offer of payment of compensation under *this* chapter ~~71 or 72 of this title~~ but controversy relates to the amount of compensation due, the case is brought before the workers' compensation judge for adjudication of the controversy, and the award granted by the judge is greater than the amount paid or offered by the insurer, reasonable attorney fees and costs as established by the workers' compensation judge if the case has gone to a hearing may be awarded by the judge in addition to the amount of compensation.

(2) An award of attorney fees under subsection (1) may be made only if it is determined that the actions of the insurer were unreasonable. Any written offer of payment made 30 days or more before the date of hearing must be considered a valid offer of payment for the purposes of this section.

(3) A finding of unreasonableness against an insurer made under this section does not constitute a finding that the insurer acted in bad faith or violated the unfair trade practices provisions of Title 33, chapter 18.

(4) Attorney fees may be awarded only under the provisions of subsections (1) and (2) and may not be awarded under the common fund doctrine or any other action or doctrine in law or equity."

Section 26. Section 39-71-743, MCA, is amended to read:

"**39-71-743. Assignment or attachment of payments.** (1) Payments under this chapter may not be assignable, subject to attachment or garnishment, or held liable in any way for debts, except:

(a) as provided in 71-3-1118;

(b) a portion of any lump-sum award or periodic payment to pay a monetary obligation for current or past-due child support, subject to the limitations in subsection (2), whenever the support obligation is established by order of a court of competent jurisdiction or by order rendered in an administrative process authorized by state law; or

(c) as provided in 53-2-612 or 53-2-613 for medical benefits paid pursuant to ~~chapter 71 or 72 of~~ this ~~title~~ *chapter*.

(2) Payments under this chapter are subject to assignment, attachment, or garnishment for child support as follows:

(a) for any periodic payment, an amount up to the percentage amount established in the guidelines promulgated by the department of public health and human services pursuant to 40-5-209; or

(b) for any lump-sum award, an amount up to that portion of the award that is approved for payment on the basis of a past-due child support obligation.

(3) After determination that the claim is covered under the Workers' Compensation Act ~~or Occupational Disease Act of Montana~~, the liability for payment of the claim is the responsibility of the appropriate workers' compensation insurer. Except as provided in 39-71-704(7), a fee or charge is not

payable by the injured worker for treatment of injuries sustained if liability is accepted by the insurer."

Section 27. Section 39-71-915, MCA, is amended to read:

"39-71-915. Assessment of insurer — employers — definition — collection. (1) As used in this section, "paid losses" means the following benefits paid during the preceding calendar year for injuries covered by the ~~Montana~~ Workers' Compensation Act ~~and the Occupational Disease Act of Montana~~ without regard to the application of any deductible, regardless of whether the employer or the insurer pays the losses:

(a) total compensation benefits paid; and

(b) except for medical benefits in excess of $200,000 for each occurrence that are exempt from assessment, total medical benefits paid for medical treatment rendered to an injured worker, including hospital treatment and prescription drugs.

(2) The fund must be maintained by assessing each plan No. 1 employer, each employer insured by a plan No. 2 insurer, plan No. 3, the state fund, with respect to claims arising before July 1, 1990, and each employer insured by plan No. 3, the state fund. The assessment amount is the total amount of paid losses reimbursed from the fund in the preceding calendar year and the expenses of administration less other income. The total assessment amount to be collected must be allocated among plan No. 1 employers, plan No. 2 employers, plan No. 3, the state fund, and plan No. 3 employers, based on a proportionate share of paid losses for the calendar year preceding the year in which the assessment is collected. The board of investments shall invest the money of the fund, and the investment income must be deposited in the fund.

(3) On or before May 31 each year, the department shall notify each plan No. 1 employer, plan No. 2 insurer, and plan No. 3, the state fund, of the amount to be assessed for the ensuing fiscal year. The amount to be assessed against the state fund must separately identify the amount attributed to claims arising before July 1, 1990, and the amount attributable to state fund claims arising on or after July 1, 1990. On or before April 30 each year, the department, in consultation with the advisory organization designated under 33-16-1023, shall notify plan No. 2 insurers and plan No. 3 of the premium surcharge rate to be effective for policies written or renewed on and after July 1 in that year.

(4) The portion of the plan No. 1 assessment assessed against an individual plan No. 1 employer is a proportionate amount of total plan No. 1 paid losses during the preceding calendar year that is equal to the percentage that the total paid losses of the individual plan No. 1 employer bore to the total paid losses of all plan No. 1 employers during the preceding calendar year.

(5) The portion of the assessment attributable to state fund claims arising before July 1, 1990, is the proportionate amount that is equal to the percentage that total paid losses for those claims during the preceding calendar year bore to the total paid losses for all plans in the preceding calendar year. As required by 39-71-2352, the state fund may not pass along to insured employers the cost of the subsequent injury fund assessment that is attributable to claims arising before July 1, 1990.

(6) The remaining portion of the assessment must be paid by way of a surcharge on premiums paid by employers being insured by a plan No. 2 insurer or plan No. 3, the state fund, for policies written or renewed annually on or after July 1. The surcharge rate must be computed by dividing the remaining portion

of the assessment by the total amount of premiums paid by employers insured under plan No. 2 or plan No. 3 in the previous calendar year. The numerator for the calculation must be adjusted as provided by subsection (9).

(7) Each plan No. 2 insurer providing workers' compensation insurance and plan No. 3, the state fund, shall collect from its policyholders the assessment premium surcharge provided for in subsection (6). When collected, the assessment premium surcharge may not constitute an element of loss for the purpose of establishing rates for workers' compensation insurance but, for the purpose of collection, must be treated as separate costs imposed upon insured employers. The total of this assessment premium surcharge must be stated as a separate cost on an insured employer's policy or on a separate document submitted by the insured employer and must be identified as "workers' compensation subsequent injury fund surcharge". Each assessment premium surcharge must be shown as a percentage of the total workers' compensation policyholder premium. This assessment premium surcharge must be collected at the same time and in the same manner that the premium for the coverage is collected. The assessment premium surcharge must be excluded from the definition of premiums for all purposes, including computation of insurance producers' commissions or premium taxes, except that an insurer may cancel a workers' compensation policy for nonpayment of the assessment premium surcharge. Cancellation must be in accordance with the procedures applicable to the nonpayment of premium. If an employer fails to remit to an insurer the total amount due for the premium and assessment premium surcharge, the amount received by the insurer must be applied to the assessment premium surcharge first and the remaining amount applied to the premium due.

(8) (a) All assessments paid to the department must be deposited in the fund.

(b) Each plan No. 1 employer shall pay its assessment by July 1.

(c) Each plan No. 2 insurer and plan No. 3, the state fund, shall remit to the department all assessment premium surcharges collected during a calendar quarter by not later than 20 days following the end of the quarter.

(d) The state fund shall pay the portion of the assessment attributable to claims arising before July 1, 1990, by July 1.

(e) If a plan No. 1 employer, a plan No. 2 insurer, or plan No. 3, the state fund, fails to timely pay to the department the assessment or assessment premium surcharge under this section, the department may impose on the plan No. 1 employer, the plan No. 2 insurer, or plan No. 3, the state fund, an administrative fine of $100 plus interest on the delinquent amount at the annual interest rate of 12%. Administrative fines and interest must be deposited in the fund.

(9) The amount of the assessment premium surcharge actually collected pursuant to subsection (7) must be compared each year to the amount assessed and upon which the premium surcharge was calculated. The amount undercollected or overcollected in any given year must be used as an adjustment to the numerator provided for by subsection (6) for the following year's assessment premium surcharge."

Section 28. Section 39-71-1105, MCA, is amended to read:

"39-71-1105. Managed care organizations — application — certification. (1) A health care provider, a group of medical service providers, or an entity with a managed care organization may make written application to the department to become certified under this section to provide managed care

to ~~injured~~ workers for injuries *or occupational diseases* that are covered under this chapter ~~or for occupational diseases that are covered under the Occupational Disease Act of Montana~~. However, this section does not authorize an organization that is formed, owned, or operated by a workers' compensation insurer or self-insured employer other than a health care provider to become certified to provide managed care. When a health care provider, a group of medical service providers, or an entity with a managed care organization is establishing a managed care organization and independent physical therapy practices exist in the community, the managed care organization is encouraged to utilize independent physical therapists as part of the managed care organization if the independent physical therapists agree to abide by all the applicable requirements for a managed care organization set forth in this section, in rules established by the department, and in the provisions of a managed care plan for which certification is being sought.

(2) Each application for certification must be accompanied by an application fee if prescribed by the department. A certificate is valid for the period prescribed by the department, unless it is revoked or suspended at an earlier date.

(3) The department shall establish by rule the form for the application for certification and the required information regarding the proposed plan for providing medical services. The information includes but is not limited to:

(a) a list of names of each individual who will provide services under the managed care plan, together with appropriate evidence of compliance with any licensing or certification requirements for that individual to practice in the state;

(b) names of the individuals who will be designated as treating physicians and who will be responsible for the coordination of medical services;

(c) a description of the times, places, and manner of providing primary medical services under the plan;

(d) a description of the times, places, and manner of providing secondary medical services, if any, that the applicants wish to provide; and

(e) satisfactory evidence of the ability to comply with any financial requirements to ensure delivery of service in accordance with the plan that the department may require.

(4) The department shall certify a group of medical service providers or an entity with a managed care organization to provide managed care under a plan if the department finds that the plan:

(a) proposes to provide coordination of services that meet quality, continuity, and other treatment standards prescribed by the department and will provide all primary medical services that may be required by this chapter in a manner that is timely and effective for the worker;

(b) provides appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of services;

(c) provides adequate methods of peer review and service utilization review to prevent excessive or inappropriate treatment, to exclude from participation in the plan those individuals who violate these treatment standards, and to provide for the resolution of any medical disputes that may arise;

(d) provides for cooperative efforts by the worker, the employer, the rehabilitation providers, and the managed care organization to promote an early return to work for the injured worker;

(e) provides a timely and accurate method of reporting to the department necessary information regarding medical and health care service cost and utilization to enable the department to determine the effectiveness of the plan;

(f) authorizes workers to receive medical treatment from a primary care physician who is not a member of the managed care organization but who maintains the worker's medical records and with whom the worker has a documented history of treatment, if that primary care physician agrees to refer the worker to the managed care organization for any specialized treatment, including physical therapy, that the worker may require and if that primary care physician agrees to comply with all the rules, terms, and conditions regarding services performed by the managed care organization. As used in this subsection *(4)*(f), "primary care physician" means a physician who is qualified to be a treating physician and who is a family practitioner, a general practitioner, an internal medicine practitioner, or a chiropractor.

(g) complies with any other requirements determined by department rule to be necessary to provide quality medical services and health care to injured workers.

(5) The department shall refuse to certify or may revoke or suspend the certification of a health care provider, a group of medical service providers, or an entity with a managed care organization to provide managed care if the department finds that:

(a) the plan for providing medical care services fails to meet the requirements of this section; and

(b) service under the plan is not being provided in accordance with the terms of a certified plan."

Section 29. Section 39-71-2401, MCA, is amended to read:

"39-71-2401. Disputes — jurisdiction — settlement requirements — mediation. (1) A dispute concerning benefits arising under this chapter ~~or chapter 72~~, other than the disputes described in subsection (2), must be brought before a department mediator as provided in this part. If a dispute still exists after the parties satisfy the mediation requirements in this part, either party may petition the workers' compensation court for a resolution.

(2) A dispute arising under this chapter that does not concern benefits or a dispute for which a specific provision of this chapter gives the department jurisdiction must be brought before the department.

(3) An appeal from a department order may be made to the workers' compensation court.

(4) Except as otherwise provided in this chapter, before a party may bring a dispute concerning benefits before a mediator, the parties shall attempt to settle as follows:

(a) The party making a demand shall present the other party with a specific written demand that contains sufficient explanation and documentary evidence to enable the other party to thoroughly evaluate the demand.

(b) The party receiving the demand shall respond in writing within 15 working days of receipt. If the demand is denied in whole or in part, the response shall state the basis of the denial.

(c) Upon motion of a party or upon the mediator's own motion, the mediator has the authority to dismiss a petition if he finds that either party did not comply

with this subsection. A decision dismissing a petition under this subsection must be in writing and must state in detail the grounds for dismissal. The mediator's decision may be reviewed by the workers' compensation court upon motion of a party.

(d) Nothing in this subsection relieves a party of an obligation otherwise contained in this chapter."

Section 30. Section 39-71-2406, MCA, is amended to read:

"39-71-2406. Purpose. The purpose of this part is to prevent when possible the filing in the workers' compensation court of actions by claimants or insurers relating to claims under ~~chapter 71 or 72 of~~ this ~~title~~ *chapter* if an equitable and reasonable resolution of the dispute may be effected at an earlier stage. To achieve this purpose, this part provides for a procedure for mandatory, nonbinding mediation. It is the intent of this part that the mediation process be used to resolve cases on an informal basis at minimal cost to the parties, and to this end, the parties are required to fully present their cases at the mediation level. However, if a cause proceeds to the workers' compensation court, the parties are not precluded from presenting additional evidence before the court. If a new issue is raised at the workers' compensation court that was not raised at mediation, the court shall remand the issue to the mediator for consideration."

Section 31. Section 39-71-2408, MCA, is amended to read:

"39-71-2408. Mandatory, nonbinding mediation. (1) Except as otherwise provided, in a dispute arising under ~~chapter 71 or 72 of~~ this ~~title~~ *chapter*, the insurer and claimant shall mediate any issue concerning benefits and the mediator shall issue a report following the mediation process recommending a solution to the dispute before either party may file a petition in the workers' compensation court.

(2) The resolution recommended by the mediator is without administrative or judicial authority and is not binding on the parties."

Section 32. Section 39-71-2411, MCA, is amended to read:

"39-71-2411. Mediation procedure. (1) Except as otherwise provided, a claimant or an insurer having a dispute relating to benefits under ~~chapter 71 or 72 of~~ this ~~title~~ *chapter* may petition the department for mediation of the dispute.

(2) A party may take part in mediation proceedings with or without representation.

(3) The mediator shall review the department file for the case and may receive any additional documentation or argument either party submits.

(4) The mediator shall request that each party offer argument summarizing the party's position. A party's argument must fully present the party's case. The argument is not limited by the rules of evidence.

(5) After the parties have presented all their information and argument to the mediator, the mediator shall recommend a solution to the parties within a reasonable time to be established by rule.

(6) A party shall notify the mediator within 25 days of the mailing of the mediator's report whether the party accepts the mediator's recommendation. If either party does not accept the mediator's recommendation, the party may petition the workers' compensation court for resolution of the dispute.

(7) (a) If a mediator determines that either party failed to cooperate in the mediation process, the mediator shall prepare a written report setting forth the

determination and the grounds for the determination. The report must be mailed to the parties and to the workers' compensation court. Unless a party disputes the determination as set forth in subsection (7)(c), the parties shall repeat the mediation process, but only one time.

(b) A mediator may determine that a party has failed to cooperate in the mediation process only if the party failed to:

(i) supply information or offer a summary of the party's position as reasonably requested by the mediator;

(ii) attend scheduled mediation conferences unless excused by the mediator; or

(iii) listen to and review the information and position offered by the opposing party.

(c) If a party disputes a mediator's determination that the party failed to cooperate in the mediation process, the party may file a petition with the workers' compensation court. Upon receipt of a petition, the court shall summon the parties and the mediator to determine by oral discussion whether the mediator's determination of noncooperation is supportable. If the court finds that the mediator's determination is supportable, the court may order the parties to attempt a second time to mediate their dispute."

Section 33. Section 39-73-104, MCA, is amended to read:

"39-73-104. Eligibility requirements for benefits. Payment ~~shall~~ *must* be made under this chapter to any person who:

(1) has silicosis, as defined in 39-73-101, ~~which~~ *that* results in ~~his~~ *the person's* total disability so as to render it impossible for ~~him~~ *the person* to follow continuously any substantially gainful occupation;

(2) has resided in and been an inhabitant of the state of Montana for 10 years or more immediately preceding the date of the application;

(3) is not receiving, with respect to any month for which ~~he~~ *the person* would receive a payment under this chapter, compensation under ~~The Occupational Disease Act of Montana, as provided by chapter 72 of this title~~ *[section 4]*, which will equal the sum of $200."

Section 34. Section 39-73-107, MCA, is amended to read:

"39-73-107. Amount of payments. Subject to the provisions of this chapter and the deductions provided in this chapter, any person who has silicosis and who has, subject to the regulations and standards of the department of labor and industry, been determined by the department to be entitled payment under this chapter for silicosis must be granted a payment by the department of $250 a month, subject to any additional appropriations. If the person is receiving payments under ~~the Occupational Disease Act of Montana, as provided by chapter 72 of this title,~~ *[section 4]* that are less in the aggregate than $200, then the person is entitled to a payment under this chapter of the difference between the amount received under ~~the Occupational Disease Act of Montana, as provided by chapter 72 of this title~~ *[section 4]*, and $250 a month. The legislature shall authorize additional appropriations that may be necessary to make the increased monthly payments provided in this section."

Section 35. Section 45-6-301, MCA, is amended to read:

"45-6-301. Theft. (1) A person commits the offense of theft when the person purposely or knowingly obtains or exerts unauthorized control over property of the owner and:

(a) has the purpose of depriving the owner of the property;

(b) purposely or knowingly uses, conceals, or abandons the property in a manner that deprives the owner of the property; or

(c) uses, conceals, or abandons the property knowing that the use, concealment, or abandonment probably will deprive the owner of the property.

(2) A person commits the offense of theft when the person purposely or knowingly obtains by threat or deception control over property of the owner and:

(a) has the purpose of depriving the owner of the property;

(b) purposely or knowingly uses, conceals, or abandons the property in a manner that deprives the owner of the property; or

(c) uses, conceals, or abandons the property knowing that the use, concealment, or abandonment probably will deprive the owner of the property.

(3) A person commits the offense of theft when the person purposely or knowingly obtains control over stolen property knowing the property to have been stolen by another and:

(a) has the purpose of depriving the owner of the property;

(b) purposely or knowingly uses, conceals, or abandons the property in a manner that deprives the owner of the property; or

(c) uses, conceals, or abandons the property knowing that the use, concealment, or abandonment probably will deprive the owner of the property.

(4) A person commits the offense of theft when the person purposely or knowingly obtains or exerts unauthorized control over any part of any public assistance provided under Title 52 or 53 by a state or county agency, regardless of the original source of assistance, by means of:

(a) a knowingly false statement, representation, or impersonation; or

(b) a fraudulent scheme or device.

(5) A person commits the offense of theft when the person purposely or knowingly obtains or exerts or helps another obtain or exert unauthorized control over any part of any benefits provided under Title 39, chapter 71 ~~or 72~~, by means of:

(a) a knowingly false statement, representation, or impersonation; or

(b) deception or other fraudulent action.

(6) (a) A person commits the offense of theft when the person purposely or knowingly commits insurance fraud as provided in 33-1-1202 or 33-1-1302; or

(b) purposely or knowingly diverts or misappropriates insurance premiums as provided in 33-17-1102.

(7) A person commits the offense of theft of property by embezzlement when, with the purpose to deprive the owner of the property, the person:

(a) purposely or knowingly obtains or exerts unauthorized control over property of the person's employer or over property entrusted to the person; or

(b) purposely or knowingly obtains by deception control over property of the person's employer or over property entrusted to the person.

(8) (a) A person convicted of the offense of theft of property not exceeding $1,000 in value shall be fined an amount not to exceed $1,000 or be imprisoned in the county jail for a term not to exceed 6 months, or both. A person convicted of a

second offense shall be fined $1,000 or be imprisoned in the county jail for a term not to exceed 6 months, or both. A person convicted of a third or subsequent offense shall be fined $1,000 and be imprisoned in the county jail for a term of not less than 30 days or more than 6 months.

(b) Except as provided in subsection (8)(c), a person convicted of the offense of theft of property exceeding $1,000 in value or theft of any commonly domesticated hoofed animal shall be fined an amount not to exceed $50,000 or be imprisoned in a state prison for a term not to exceed 10 years, or both.

(c) A person convicted of the offense of theft of property exceeding $10,000 in value by embezzlement shall be imprisoned in a state prison for a term of not less than 1 year or more than 10 years and may be fined an amount not to exceed $50,000. The court may, in its discretion, place the person on probation with the requirement that restitution be made under terms set by the court. If the terms are not met, the required prison term may be ordered.

(9) Amounts involved in thefts committed pursuant to a common scheme or the same transaction, whether from the same person or several persons, may be aggregated in determining the value of the property."

Section 36. Section 71-3-1118, MCA, is amended to read:

"71-3-1118. Applicability. (1) Except as provided in subsection (2), this part does not apply to compensation awarded to workers for injury, disease, or death pursuant to the Workers' Compensation Act ~~or the Occupational Disease Act of Montana~~.

(2) This part applies to all payments awarded for medical, therapy, chiropractic, dentistry, counseling, and hospital services pursuant to the acts referred to in subsection (1).

(3) This part does not apply to any benefits payable under:

(a) a policy of life insurance or group life insurance;

(b) a contract of disability insurance, except benefits payable in reimbursement for services rendered by a physician, nurse, physical therapist, occupational therapist, chiropractor, dentist, psychologist, licensed social worker, licensed professional counselor, hospital, or ambulatory surgical facility; or

(c) an annuity contract or to pension benefits payable under a qualified pension plan."

Section 37. Section 85-5-101, MCA, is amended to read:

"85-5-101. Appointment of water commissioners. (1) Whenever the rights of persons to use the waters of any stream, ditch or extension of ditch, watercourse, spring, lake, reservoir, or other source of supply have been determined by a decree of a court of competent jurisdiction, including temporary preliminary, preliminary, and final decrees issued by a water judge, it is the duty of the judge of the district court having jurisdiction of the subject matter, upon the application of the owners of at least 15% of the water rights affected by the decree, in the exercise of the judge's discretion, to appoint one or more commissioners. The commissioners have authority to admeasure and distribute to the parties owning water rights in the source affected by the decree the waters to which they are entitled, according to their rights as fixed by the decree and by any certificates and permits issued under chapter 2 of this title. When petitioners make proper showing that they are not able to obtain the application of the owners of at least 15% of the water rights affected and they are unable to

obtain the water to which they are entitled, the judge of the district court having jurisdiction may appoint a water commissioner.

(2) When the existing rights of all appropriators from a source or in an area have been determined in a temporary preliminary decree, preliminary decree, or final decree issued under chapter 2 of this title, the judge of the district court may, upon application by both the department of natural resources and conservation and one or more holders of valid water rights in the source, appoint a water commissioner. The water commissioner shall distribute to the appropriators, from the source or in the area, the water to which they are entitled.

(3) The department of natural resources and conservation or any person or corporation operating under contract with the department or any other owner of stored waters may petition the court to have stored waters distributed by the water commissioners appointed by the district court. The court may order the commissioner or commissioners appointed by the court to distribute stored water when and as released to water users entitled to the use of the water.

(4) At the time of the appointment of a water commissioner or commissioners, the district court shall fix their compensation, require a commissioner or commissioners to purchase a workers' compensation insurance policy and elect coverage on themselves, and require the owners and users of the distributed waters, including permittees and certificate holders, to pay their proportionate share of fees and compensation, including the cost of workers' compensation insurance purchased by a water commissioner or commissioners. The judge may include the department in the apportionment of costs if it applied for the appointment of a water commissioner under subsection (2).

(5) Upon the application of the board or boards of one or more irrigation districts entitled to the use of water stored in a reservoir that is turned into the natural channel of any stream and withdrawn or diverted at a point downstream for beneficial use, the district court of the judicial district where the most irrigable acres of the irrigation district or districts are situated may appoint a water commissioner to equitably admeasure and distribute stored water to the irrigation district or districts from the channel of the stream into which it has been turned. A commissioner appointed under this subsection has the powers of any commissioner appointed under this chapter, limited only by the purposes of this subsection. A commissioner's compensation is set by the appointing judge and paid by each district and other users of stored water affected by the admeasurement and distribution of the stored water. In all other matters the provisions of this chapter apply so long as they are consistent with this subsection.

(6) A water commissioner appointed by a district court is not an employee of the judicial branch, a local government, or a water user.

(7) A water commissioner who fails to obtain workers' compensation insurance coverage required by subsection (4) is precluded from receiving benefits under Title 39, chapter 71 ~~or 72~~, as a result of the performance of duties as a water commissioner."

Section 38. Repealer. Sections 39-72-101, 39-72-102, 39-72-103, 39-72-201, 39-72-202, 39-72-203, 39-72-204, 39-72-206, 39-72-301, 39-72-302, 39-72-303, 39-72-305, 39-72-310, 39-72-401, 39-72-402, 39-72-403, 39-72-404, 39-72-405, 39-72-408, 39-72-509, 39-72-601, 39-72-602, 39-72-606, 39-72-607, 39-72-608, 39-72-701, 39-72-703, 39-72-704, 39-72-705, 39-72-706, 39-72-707, 39-72-708, 39-72-709, 39-72-711, 39-72-712, and 39-72-714, MCA, are repealed.

Section 39. Codification instruction. (1) [Section 1] is intended to be codified as an integral part of Title 39, chapter 71, part 1, and the provisions of Title 39, chapter 71, part 1, apply to [section 1].

(2) [Sections 2 through 5] are intended to be codified as an integral part of Title 39, chapter 71, part 7, and the provisions of Title 39, chapter 71, part 7, apply to [sections 2 through 5].

Section 40. Coordination instruction. If House Bill No. 126 is passed and approved and if it includes a section that repeals 39-71-416, then [section 21 of this act], amending 39-71-416, is void.

Section 41. Direction to code commissioner. The code commissioner is directed to change any reference to chapter 72 of Title 39 that appears in legislation enacted by the 2005 legislature to a reference to chapter 71 of Title 39.

Section 42. Severability. If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

Section 43. Effective date — applicability. [This act] is effective July 1, 2005, and applies to occupational diseases that occur on or after July 1, 2005.

Approved April 25, 2005

CHAPTER NO. 417

[SB 487]

AN ACT REVISING LAWS ON SCHOOL BUS SAFETY; INCREASING THE FOOTAGE REQUIREMENT IN WHICH A MOTOR VEHICLE MUST STOP BEFORE REACHING A SCHOOL BUS WHEN BUS LIGHTS ARE FLASHING; PROVIDING THAT A PERSON WHO OBSERVES A VIOLATION MAY PREPARE A VIOLATION REPORT; AMENDING SECTIONS 61-8-351 AND 61-8-715, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE.

Be it enacted by the Legislature of the State of Montana:

Section 1. Section 61-8-351, MCA, is amended to read:

"61-8-351. Meeting or passing school bus — *vehicle operator liability for violation* — penalty. (1) ~~The driver of a vehicle upon a highway or street either inside or outside the corporate limits of any city or town upon meeting or~~ *Upon* overtaking from either direction ~~any~~ *a* school bus that has stopped on the highway or street to receive or discharge ~~any~~ school children, *a driver of a motor vehicle*:

(a) shall stop the *motor* vehicle not less than ~~10~~ *approximately 15* feet before reaching the school bus when there is in operation on the bus a visual flashing red signal as specified in 61-9-402; and

(b) may not proceed until the children have entered the school bus or have alighted and reached the side of the highway or street and until the school bus ceases operation of its visual flashing red signal.

(2) The driver of a *motor* vehicle shall slow to a rate of speed that is reasonable under the conditions existing at the point of operation and must be

SENATE BILL NO. 481

INTRODUCED BY COCCHIARELLA

A BILL FOR AN ACT ENTITLED: "AN ACT MERGING OCCUPATIONAL DISEASES INTO THE WORKERS' COMPENSATION ACT; ESTABLISHING LEGISLATIVE INTENT TOWARD OCCUPATIONAL DISEASES AS PUBLIC POLICY; DEFINING "OCCUPATIONAL DISEASE"; PROVIDING FOR THE LIABILITY OF INSURERS AND COMPENSATION FOR OCCUPATIONAL DISEASES UNDER THE WORKERS' COMPENSATION ACT; PROVIDING FOR TIME FOR CLAIMS TO BE PRESENTED; AMENDING SECTIONS 2-15-2015, 30-9A-109, 37-1-131, 39-71-105, 39-71-106, 39-71-107, 39-71-116, 39-71-201, 39-71-206, 39-71-211, 39-71-315, 39-71-316, 39-71-317, 39-71-403, 39-71-407, 39-71-416, 39-71-525, 39-71-601, 39-71-603, 39-71-612, 39-71-743, 39-71-915, 39-71-1105, 39-71-2401, 39-71-2406, 39-71-2408, 39-71-2411, 39-73-104, 39-73-107, 45-6-301, 71-3-1118, AND 85-5-101, MCA; REPEALING SECTIONS 39-72-101, 39-72-102, 39-72-103, 39-72-201, 39-72-202, 39-72-203, 39-72-204, 39-72-206, 39-72-301, 39-72-302, 39-72-303, 39-72-305, 39-72-310, 39-72-401, 39-72-402, 39-72-403, 39-72-404, 39-72-405, 39-72-408, 39-72-509, 39-72-601, 39-72-602, 39-72-606, 39-72-607, 39-72-608, 39-72-701, 39-72-703, 39-72-704, 39-72-705, 39-72-706, 39-72-707, 39-72-708, 39-72-709, 39-72-711, 39-72-712, AND 39-72-714, MCA; AND PROVIDING AN EFFECTIVE DATE AND AN APPLICABILITY DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1. Applicability of workers' compensation act -- exceptions.** Except as provided in 39-71-407, 39-71-601, and 39-71-603, this chapter applies to injuries and occupational diseases.

NEW SECTION. **Section 2. Compensation for occupational diseases and medical benefits -- diminution of compensation.** (1) Compensation for occupational diseases must be equal to the compensation and medical benefits provided for injuries in this chapter.

(2) ~~For an occupational disease, compensation payable to the claimant, the claimant's beneficiaries, or the claimant's dependents must be diminished by the amount of any compensation paid or to be paid to the claimant or the claimant's beneficiaries or dependents for the same condition for which benefits are received or may be claimed for an injury~~ WHEN THE SAME MEDICAL CONDITION MAY BE CLAIMED AS AN INJURY AND AN

OCCUPATIONAL DISEASE, COMPENSATION PAYABLE TO THE CLAIMANT, THE CLAIMANT'S BENEFICIARIES, OR THE CLAIMANT'S DEPENDENTS MAY NOT BE DUPLICATED FOR THE SAME CONDITIONS OVER THE SAME TIME PERIOD.

NEW SECTION. **Section 3. Autopsy.** Upon the filing of a claim for compensation for death caused by an occupational disease, if an autopsy is necessary to determine the cause of death, an autopsy may be requested by an insurer. The autopsy must be made under the supervision of the county coroner or a medical examiner. The expense of the autopsy must be paid by the insurer.

NEW SECTION. **Section 4. Benefits for pneumoconiosis.** (1) Pneumoconiosis is an occupational disease that is compensable under this part. However, any benefits granted a claimant under this chapter for pneumoconiosis must be reduced, but not below zero, by an amount equal to the benefits granted the claimant under any program under federal law that pays benefits for a claimant suffering disability from pneumoconiosis.

(2) "Pneumoconiosis" means a chronic dust disease of the lungs arising out of employment in coal mines and includes anthracosis, coal workers' pneumoconiosis, silicosis, or anthracosilicosis arising out of employment.

NEW SECTION. **Section 5. Prohibiting supplementing of benefits.** A person receiving compensation or benefits under chapter 73 of this title is not entitled to compensation or benefits under this chapter.

Section 6. Section 2-15-2015, MCA, is amended to read:

"2-15-2015. Workers' compensation fraud investigation and prosecution office. There is a workers' compensation fraud investigation and prosecution office in the department of justice. The office shall investigate and prosecute cases referred by the state compensation insurance fund or the department of labor and industry on behalf of the uninsured employers' fund. The office is under the supervision and control of the attorney general and consists of:

(1) one or more investigators qualified by education, training, experience, and high professional competence in investigative procedures who shall investigate violations of the provisions of Title 39, ~~chapters~~ chapter 71 ~~and 72~~, at the request of the state compensation insurance fund or the department of labor and industry on behalf of the uninsured employers' fund; and

(2) one or more attorneys licensed to practice law in Montana who shall prosecute violations of the provisions of Title 39, ~~chapters~~ chapter 71 ~~and 72~~. The attorneys may also assist county attorneys in prosecuting violations of Title 39, ~~chapters~~ chapter 71 ~~and 72~~, without charge to the county.

(3) The state compensation insurance fund, the department of labor and industry, and the department of justice shall submit to the legislature for approval one proposed biennial budget for the workers' compensation fraud office. The proposed budget for staffing and related expenses must be based upon the needs of the state compensation insurance fund and the department of labor and industry on behalf of the uninsured employers' fund for investigating and prosecuting workers' compensation fraud."

Section 7. Section 30-9A-109, MCA, is amended to read:

"30-9A-109. Scope. (1) Except as otherwise provided in subsections (3) and (4), this chapter applies to:

(a) any transaction, regardless of its form, that creates a security interest in personal property or fixtures by contract;

(b) an agricultural lien;

(c) a sale of an account, chattel paper, payment intangible, or promissory note;

(d) a consignment;

(e) a security interest arising under 30-2-401, 30-2-505, 30-2-711(3), or 30-2A-508(5), to the extent provided in 30-9A-110; and

(f) a security interest arising under 30-4-208 or 30-5-118.

(2) The application of this chapter to a security interest in a secured obligation is not affected by the fact that the obligation is itself secured by a transaction or interest to which this chapter does not apply.

(3) This chapter does not apply to the extent that:

(a) a statute, regulation, or treaty of the United States preempts this chapter;

(b) another statute of this state expressly governs the creation, perfection, priority, or enforcement of a security interest created by this state or a governmental unit of this state;

(c) a statute of another state, a foreign country, or a governmental unit of another state or a foreign country, other than a statute generally applicable to security interests, expressly governs creation, perfection, priority, or enforcement of a security interest created by the state, country, or governmental unit; or

(d) the rights of a transferee beneficiary or nominated person under a letter of credit are independent

and superior under 30-5-134.

(4) This chapter does not apply to:

(a) a landlord's lien, other than an agricultural lien;

(b) a lien, other than an agricultural lien, given by statute or other rule of law for services or materials, but 30-9A-333 applies with respect to priority of the lien;

(c) an assignment of a claim for wages, salary, or other compensation of an employee;

(d) a sale of accounts, chattel paper, payment intangibles, or promissory notes as part of a sale of the business out of which they arose;

(e) an assignment of accounts, chattel paper, payment intangibles, or promissory notes that is for the purpose of collection only;

(f) an assignment of a right to payment under a contract to an assignee that is also obliged to perform under the contract;

(g) an assignment of a single account, payment intangible, or promissory note to an assignee in full or partial satisfaction of a preexisting indebtedness;

(h) a transfer of an interest in or an assignment of a claim under a policy of insurance, other than an assignment by or to a health care provider of a health-care-insurance receivable and any subsequent assignment of the right to payment, but 30-9A-315 and 30-9A-322 apply with respect to proceeds and priorities in proceeds;

(i) an assignment of a right represented by a judgment, other than a judgment taken on a right to payment that was collateral;

(j) a right of recoupment or setoff, but:

(i) 30-9A-340 applies with respect to the effectiveness of rights of recoupment or setoff against deposit accounts; and

(ii) 30-9A-404 applies with respect to defenses or claims of an account debtor;

(k) the creation or transfer of an interest in or lien on real property, including a lease or rents under the interest in real property, except to the extent that provision is made for:

(i) liens on real property in 30-9A-203 and 30-9A-308;

(ii) fixtures in 30-9A-334;

(iii) fixture filings in 30-9A-501, 30-9A-502, 30-9A-512, 30-9A-516, and 30-9A-519; and

(iv) security agreements covering personal and real property in 30-9A-604;

(l) an assignment of a claim arising in tort, other than a commercial tort claim, but 30-9A-315 and 30-9A-322 apply with respect to proceeds and priorities in proceeds;

(m) a transfer by a government or governmental subdivision or agency;

(n) an assignment of a deposit account in a consumer transaction, except that 30-9A-315 and 30-9A-322 apply with respect to proceeds and priorities in proceeds; or

(o) an assignment of payments made to or on behalf of claimants pursuant to Title 39, chapter 51, 71, ~~72,~~ or 73."

Section 8. Section 37-1-131, MCA, is amended to read:

"37-1-131. Duties of boards -- quorum required. Each board within the department shall:

(1) set and enforce standards and rules governing the licensing, certification, registration, and conduct of the members of the particular profession or occupation within its jurisdiction;

(2) sit in judgment in hearings for the suspension, revocation, or denial of a license of an actual or potential member of the particular profession or occupation within its jurisdiction. The hearings must be conducted by a hearing examiner when required under 37-1-121(1).

(3) suspend, revoke, or deny a license of a person who the board determines, after a hearing as provided in subsection (2), is guilty of knowingly defrauding, abusing, or aiding in the defrauding or abusing of the workers' compensation system in violation of the provisions of Title 39, chapter 71 ~~or 72~~;

(4) pay to the department its pro rata share of the assessed costs of the department under 37-1-101(6);

(5) consult with the department before the board initiates a program expansion, under existing legislation, to determine if the board has adequate money and appropriation authority to fully pay all costs associated with the proposed program expansion. The board may not expand a program if the board does not have adequate money and appropriation authority available.

(6) A board, board panel, or subcommittee convened to conduct board business must have a majority of its members, which constitutes a quorum, present to conduct business."

Section 9. Section 39-71-105, MCA, is amended to read:

"39-71-105. Declaration of public policy. For the purposes of interpreting and applying Title 39, ~~chapters~~ chapter 71 ~~and 72~~, the following is the public policy of this state:

(1) It is an objective of the Montana workers' compensation system to provide, without regard to fault,

wage supplement and medical benefits to a worker suffering from a work-related injury or disease. Wage-loss benefits are not intended to make an injured worker whole; they are intended to assist a worker at a reasonable cost to the employer. Within that limitation, the wage-loss benefit should bear a reasonable relationship to actual wages lost as a result of a work-related injury or disease.

(2) A worker's removal from the work force due to a work-related injury or disease has a negative impact on the worker, the worker's family, the employer, and the general public. Therefore, it is an objective of the workers' compensation system to return a worker to work as soon as possible after the worker has suffered a work-related injury or disease.

(3) Montana's workers' compensation and occupational disease insurance systems are intended to be primarily self-administering. Claimants should be able to speedily obtain benefits, and employers should be able to provide coverage at reasonably constant rates. To meet these objectives, the system must be designed to minimize reliance upon lawyers and the courts to obtain benefits and interpret liabilities.

(4) Title 39, ~~chapters~~ chapter 71 ~~and 72~~, must be construed according to ~~their~~ its terms and not liberally in favor of any party.

(5) It is the intent of the legislature that:

(a) stress claims, often referred to as "mental-mental claims" and "mental-physical claims", are not compensable under Montana's workers' compensation and occupational disease laws. The legislature recognizes that these claims are difficult to objectively verify and that the claims have a potential to place an economic burden on the workers' compensation and occupational disease system. The legislature also recognizes that there are other states that do not provide compensation for various categories of stress claims and that stress claims have presented economic problems for certain other jurisdictions. In addition, not all injuries are compensable under the present system, as is the case with repetitive injury claims, and it is within the legislature's authority to define the limits of the workers' compensation and occupational disease system.

(b) for occupational disease claims, because of the nature of exposure, workers should not be required to provide notice to employers of the disease as required of injuries and that the requirements for filing of claims reflect consideration of when the worker knew or should have known ~~of exposure to~~ THAT THE WORKER'S CONDITION RESULTED FROM an occupational disease. The legislature recognizes that occupational diseases in the workplace are caused by events occurring on more than a single day or work shift and that it is within the legislature's authority to define an occupational disease and establish the causal connection to the workplace."

Section 10. Section 39-71-106, MCA, is amended to read:

"39-71-106. No liability for reporting violation. A person, including but not limited to an insurer or an employer, may not be held liable for civil damages as a result of reporting in good faith information that the person believes proves a violation of the provisions of ~~chapter 72 or~~ this chapter."

Section 11. Section 39-71-107, MCA, is amended to read:

"39-71-107. Insurers to act promptly on claims -- in-state adjusters. (1) Pursuant to the public policy stated in 39-71-105, prompt claims handling practices are necessary to provide appropriate service to injured workers, to employers, and to providers who are the customers of the workers' compensation system.

(2) All workers' compensation and occupational disease claims filed pursuant to the Workers' Compensation Act ~~and the Occupational Disease Act of Montana~~ must be adjusted by a person in Montana. For a claim to be considered as adjusted by a person in Montana, the person adjusting the claim is required to determine the entitlement to benefits, authorize payment of all benefits due, manage the claim, have authority to settle the claim, maintain an office located in Montana, and adjust Montana claims from that office. Use of a mailbox or maildrop in Montana does not constitute maintaining an office in Montana.

(3) An insurer shall maintain the documents related to each claim filed with the insurer under the Workers' Compensation Act ~~and the Occupational Disease Act of Montana~~ at the Montana office of the person adjusting the claim in Montana until the claim is settled. The documents may be either original documents or duplicates of the original documents and must be maintained in a manner that allows the documents to be retrieved from that office and copied at the request of the claimant or the department. Settled claim files stored outside of the adjuster's office must be made available within 48 hours of a request for the file. Electronic or optically imaged documents are permitted.

(4) An insurer shall provide to the claimant:

(a) a written statement of the reasons that a claim is being denied at the time of denial;

(b) whenever benefits requested by a claimant are denied, a written explanation of how the claimant may appeal an insurer's decision; and

(c) a written explanation of the amount of wage loss benefits being paid to the claimant, along with an explanation of the calculation used to compute those benefits. The explanation must be sent within 7 days of the initial payment of the benefit.

(5) An insurer shall:

(a) begin making payments that are due on a claim within 14 days of acceptance of the claim, unless the insurer promptly notifies the claimant that the insurer needs additional information in order to begin paying benefits and specifies the information needed; and

(b) pay settlements within 30 days of the date the department issues an order approving the settlement.

(6) An insurer may not make payments pursuant to 39-71-608 or any other reservation of rights for more than 90 days without:

(a) written consent of the claimant; or

(b) approval of the department.

(7) The department may adopt rules to implement this section.

(8) (a) For purposes of this section, "settled claim" means a department-approved or court-ordered compromise of benefits between a claimant and an insurer or a claim that was paid in full.

(b) The term does not include a claim in which there has been only a lump-sum advance of benefits."

Section 12. Section 39-71-116, MCA, is amended to read:

"39-71-116. Definitions. Unless the context otherwise requires, in this chapter, the following definitions apply:

(1) "Actual wage loss" means that the wages that a worker earns or is qualified to earn after the worker reaches maximum healing are less than the actual wages the worker received at the time of the injury.

(2) "Administer and pay" includes all actions by the state fund under the Workers' Compensation Act ~~and the Occupational Disease Act of Montana~~ necessary to:

(a) investigation, review, and settlement of claims;

(b) payment of benefits;

(c) setting of reserves;

(d) furnishing of services and facilities; and

(e) use of actuarial, audit, accounting, vocational rehabilitation, and legal services.

(3) "Aid or sustenance" means a public or private subsidy made to provide a means of support, maintenance, or subsistence for the recipient.

(4) "Average weekly wage" means the mean weekly earnings of all employees under covered employment, as defined and established annually by the department. It is established at the nearest whole dollar number and must be adopted by the department before July 1 of each year.

(5) "Beneficiary" means:

(a) a surviving spouse living with or legally entitled to be supported by the deceased at the time of injury;

(b) an unmarried child under 18 years of age;

(c) an unmarried child under 22 years of age who is a full-time student in an accredited school or is enrolled in an accredited apprenticeship program;

(d) an invalid child over 18 years of age who is dependent, as defined in 26 U.S.C. 152, upon the decedent for support at the time of injury;

(e) a parent who is dependent, as defined in 26 U.S.C. 152, upon the decedent for support at the time of the injury if a beneficiary, as defined in subsections (5)(a) through (5)(d), does not exist; and

(f) a brother or sister under 18 years of age if dependent, as defined in 26 U.S.C. 152, upon the decedent for support at the time of the injury but only until the age of 18 years and only when a beneficiary, as defined in subsections (5)(a) through (5)(e), does not exist.

(6) "Business partner" means the community, governmental entity, or business organization that provides the premises for work-based learning activities for students.

(7) "Casual employment" means employment not in the usual course of the trade, business, profession, or occupation of the employer.

(8) "Child" includes a posthumous child, a dependent stepchild, and a child legally adopted prior to the injury.

(9) "Construction industry" means the major group of general contractors and operative builders, heavy construction (other than building construction) contractors, and special trade contractors listed in major group 23 in the North American Industry Classification System Manual. The term does not include office workers, design professionals, salespersons, estimators, or any other related employment that is not directly involved on a regular basis in the provision of physical labor at a construction or renovation site.

(10) "Days" means calendar days, unless otherwise specified.

(11) "Department" means the department of labor and industry.

(12) "Fiscal year" means the period of time between July 1 and the succeeding June 30.

(13) "Household or domestic employment" means employment of persons other than members of the household for the purpose of tending to the aid and comfort of the employer or members of the employer's family, including but not limited to housecleaning and yard work, but does not include employment beyond the scope of normal household or domestic duties, such as home health care or domiciliary care.

(14) "Insurer" means an employer bound by compensation plan No. 1, an insurance company transacting business under compensation plan No. 2, or the state fund under compensation plan No. 3.

(15) "Invalid" means one who is physically or mentally incapacitated.

(16) "Limited liability company" is as defined in 35-8-102.

(17) "Maintenance care" means treatment designed to provide the optimum state of health while minimizing recurrence of the clinical status.

(18) "Medical stability", "maximum healing", or "maximum medical healing" means a point in the healing process when further material improvement would not be reasonably expected from primary medical treatment.

(19) "Objective medical findings" means medical evidence, including range of motion, atrophy, muscle strength, muscle spasm, or other diagnostic evidence, substantiated by clinical findings.

(20) (a) "Occupational disease" means harm, damage, or death arising out of or contracted in the course and scope of employment caused by events occurring on more than a single day or work shift.

(b) The term does not include a physical or mental condition arising from emotional or mental stress or from a nonphysical stimulus or activity.

~~(20)~~(21) "Order" means any decision, rule, direction, requirement, or standard of the department or any other determination arrived at or decision made by the department.

~~(21)~~(22) "Palliative care" means treatment designed to reduce or ease symptoms without curing the underlying cause of the symptoms.

~~(22)~~(23) "Payroll", "annual payroll", or "annual payroll for the preceding year" means the average annual payroll of the employer for the preceding calendar year or, if the employer has not operated a sufficient or any length of time during the calendar year, 12 times the average monthly payroll for the current year. However, an estimate may be made by the department for any employer starting in business if average payrolls are not available. This estimate must be adjusted by additional payment by the employer or refund by the department, as the case may actually be, on December 31 of the current year. An employer's payroll must be computed by calculating all wages, as defined in 39-71-123, that are paid by an employer.

~~(23)~~(24) "Permanent partial disability" means a physical condition in which a worker, after reaching maximum medical healing:

(a) has a permanent impairment established by objective medical findings;

(b) is able to return to work in some capacity but the permanent impairment impairs the worker's ability to work; and

(c) has an actual wage loss as a result of the injury.

~~(24)~~(25) "Permanent total disability" means a physical condition resulting from injury as defined in this chapter, after a worker reaches maximum medical healing, in which a worker does not have a reasonable prospect of physically performing regular employment. Regular employment means work on a recurring basis performed for remuneration in a trade, business, profession, or other occupation in this state. Lack of immediate job openings is not a factor to be considered in determining if a worker is permanently totally disabled.

~~(25)~~(26) The "plant of the employer" includes the place of business of a third person while the employer has access to or control over the place of business for the purpose of carrying on the employer's usual trade, business, or occupation.

~~(26)~~(27) "Primary medical services" means treatment prescribed by a treating physician, for conditions resulting from the injury, necessary for achieving medical stability.

~~(27)~~(28) "Public corporation" means the state or a county, municipal corporation, school district, city, city under a commission form of government or special charter, town, or village.

~~(28)~~(29) "Reasonably safe place to work" means that the place of employment has been made as free from danger to the life or safety of the employee as the nature of the employment will reasonably permit.

~~(29)~~(30) "Reasonably safe tools and appliances" are tools and appliances that are adapted to and that are reasonably safe for use for the particular purpose for which they are furnished.

~~(30)~~(31) (a) "Secondary medical services" means those medical services or appliances that are considered not medically necessary for medical stability. The services and appliances include but are not limited to spas or hot tubs, work hardening, physical restoration programs and other restoration programs designed to address disability and not impairment, or equipment offered by individuals, clinics, groups, hospitals, or rehabilitation facilities.

(b) (i) As used in this subsection ~~(30)~~ (31), "disability" means a condition in which a worker's ability to engage in gainful employment is diminished as a result of physical restrictions resulting from an injury. The restrictions may be combined with factors, such as the worker's age, education, work history, and other factors that affect the worker's ability to engage in gainful employment.

(ii) Disability does not mean a purely medical condition.

~~(31)~~(32) "Sole proprietor" means the person who has the exclusive legal right or title to or ownership of a business enterprise.

~~(32)~~(33) "Temporary partial disability" means a physical condition resulting from an injury, as defined

in 39-71-119, in which a worker, prior to maximum healing:

(a) is temporarily unable to return to the position held at the time of injury because of a medically determined physical restriction;

(b) returns to work in a modified or alternative employment; and

(c) suffers a partial wage loss.

~~(33)~~(34) "Temporary service contractor" means a person, firm, association, partnership, limited liability company, or corporation conducting business that hires its own employees and assigns them to clients to fill a work assignment with a finite ending date to support or supplement the client's workforce in situations resulting from employee absences, skill shortages, seasonal workloads, and special assignments and projects.

~~(34)~~(35) "Temporary total disability" means a physical condition resulting from an injury, as defined in this chapter, that results in total loss of wages and exists until the injured worker reaches maximum medical healing.

~~(35)~~(36) "Temporary worker" means a worker whose services are furnished to another on a part-time or temporary basis to fill a work assignment with a finite ending date to support or supplement a workforce in situations resulting from employee absences, skill shortages, seasonal workloads, and special assignments and projects.

~~(36)~~(37) "Treating physician" means a person who is primarily responsible for the treatment of a worker's compensable injury and is:

(a) a physician licensed by the state of Montana under Title 37, chapter 3, and has admitting privileges to practice in one or more hospitals, if any, in the area where the physician is located;

(b) a chiropractor licensed by the state of Montana under Title 37, chapter 12;

(c) a physician assistant-certified licensed by the state of Montana under Title 37, chapter 20, if there is not a treating physician, as provided for in subsection ~~(36)(a)~~ (37)(a), in the area where the physician assistant-certified is located;

(d) an osteopath licensed by the state of Montana under Title 37, chapter 3;

(e) a dentist licensed by the state of Montana under Title 37, chapter 4;

(f) for a claimant residing out of state or upon approval of the insurer, a treating physician defined in subsections ~~(36)(a)~~ (37)(a) through ~~(36)(e)~~ (37)(e) who is licensed or certified in another state; or

(g) an advanced practice registered nurse licensed by the state of Montana under Title 37, chapter 8, recognized by the board of nursing as a nurse practitioner or a clinical nurse specialist, and practicing in

consultation with a physician licensed under Title 37, chapter 3, if there is not a treating physician, as provided for in subsection ~~(36)(a)~~ (37)(a), in the area in which the advanced practice registered nurse is located.

~~(37)~~(38) "Work-based learning activities" means job training and work experience conducted on the premises of a business partner as a component of school-based learning activities authorized by an elementary, secondary, or postsecondary educational institution.

~~(38)~~(39) "Year", unless otherwise specified, means calendar year."

Section 13. Section 39-71-201, MCA, is amended to read:

"39-71-201. Administration fund. (1) A workers' compensation administration fund is established out of which all costs of administering the Workers' Compensation ~~and Occupational Disease Acts~~ Act and the statutory occupational safety acts that the department is required to administer, with the exception of the subsequent injury fund, as provided for in 39-71-907, and the uninsured employers' fund, are to be paid upon lawful appropriation. The department shall collect and deposit in the state treasury to the credit of the workers' compensation administration fund:

(a) all fees and penalties provided in 39-71-205, 39-71-223, 39-71-304, 39-71-307, 39-71-308, 39-71-315, 39-71-316, 39-71-401(6), 39-71-2204, 39-71-2205, and 39-71-2337; and

(b) all fees paid by an assessment of 3% of paid losses, plus administrative fines and interest provided by this section.

(2) For the purposes of this section, paid losses include the following benefits paid during the preceding calendar year for injuries covered by the Workers' Compensation Act ~~and the Occupational Disease Act of Montana~~ without regard to the application of any deductible whether the employer or the insurer pays the losses:

(a) total compensation benefits paid; and

(b) except for medical benefits in excess of $200,000 for each occurrence that are exempt from assessment, total medical benefits paid for medical treatment rendered to an injured worker, including hospital treatment and prescription drugs.

(3) Each plan No. 1 employer, plan No. 2 insurer subject to the provisions of this section, and plan No. 3, the state fund, shall file annually on March 1 in the form and containing the information required by the department a report of paid losses pursuant to subsection (2).

(4) Each employer enrolled under compensation plan No. 1, compensation plan No. 2, or compensation plan No. 3, the state fund, shall pay a proportionate share of all costs of administering and regulating the

Workers' Compensation Act ~~and the Occupational Disease Act of Montana~~ and the statutory occupational safety acts that the department is required to administer, with the exception of the subsequent injury fund, as provided for in 39-71-907, and the uninsured employers' fund. In addition, compensation plan No. 3, the state fund, shall pay a proportionate share of these costs based upon paid losses for claims arising before July 1, 1990.

(5) (a) Each employer enrolled under compensation plan No. 1 shall pay an assessment to fund administrative and regulatory costs. The assessment is equal to 3% of the paid losses paid in the preceding calendar year by or on behalf of the plan No. 1 employer or $500, whichever is greater. Any entity, other than the department, that assumes the obligations of an employer enrolled under compensation plan No. 1 is considered to be the employer for the purposes of this section.

(b) An employer formerly enrolled under compensation plan No. 1 shall pay an assessment to fund administrative and regulatory costs. The assessment is equal to 3% of the paid losses paid in the preceding calendar year by or on behalf of the employer for claims arising out of the time when the employer was enrolled under compensation plan No. 1.

(c) Payment of the assessment provided for by this subsection (5) must be paid by the employer in:

(i) one installment due on July 1; or

(ii) two equal installments due on July 1 and December 31 of each year.

(d) If an employer fails to timely pay to the department the assessment under this section, the department may impose on the employer an administrative fine of $500 plus interest on the delinquent amount at the annual interest rate of 12%. Administrative fines and interest must be deposited in the workers' compensation administration fund.

(6) (a) Compensation plan No. 3, the state fund, shall pay an assessment to fund administrative and regulatory costs attributable to claims arising before July 1, 1990. The assessment is equal to 3% of the paid losses paid in the preceding calendar year for claims arising before July 1, 1990. As required by 39-71-2352, the state fund may not pass along to insured employers the cost of the assessment for administrative and regulatory costs that is attributable to claims arising before July 1, 1990.

(b) Payment of the assessment must be paid in:

(i) one installment due on July 1; or

(ii) two equal installments due on July 1 and December 31 of each year.

(c) If the state fund fails to timely pay to the department the assessment under this section, the department may impose on the state fund an administrative fine of $500 plus interest on the delinquent amount

at the annual interest rate of 12%. Administrative fines and interest must be deposited in the workers' compensation administration fund.

(7) (a) Each employer insured under compensation plan No. 2 or plan No. 3, the state fund, shall pay a premium surcharge to fund administrative and regulatory costs. The premium surcharge must be collected by each plan No. 2 insurer and by plan No. 3, the state fund, from each employer that it insures. The premium surcharge must be stated as a separate cost on an insured employer's policy or on a separate document submitted to the insured employer and must be identified as "workers' compensation regulatory assessment surcharge". The premium surcharge must be excluded from the definition of premiums for all purposes, including computation of insurance producers' commissions or premium taxes. However, an insurer may cancel a workers' compensation policy for nonpayment of the premium surcharge. When collected, assessments may not constitute an element of loss for the purpose of establishing rates for workers' compensation insurance but, for the purpose of collection, must be treated as a separate cost imposed upon insured employers.

(b) The amount to be funded by the premium surcharge is equal to 3% of the paid losses paid in the preceding calendar year by or on behalf of all plan No. 2 insurers and 3% of paid losses for claims arising on or after July 1, 1990, for plan No. 3, the state fund, plus or minus any adjustments as provided by subsection (7)(f). The amount to be funded must be divided by the total premium paid by all employers enrolled under compensation plan No. 2 or plan No. 3 during the preceding calendar year. A single premium surcharge rate, applicable to all employers enrolled in compensation plan No. 2 or plan No. 3, must be calculated annually by the department by not later than April 30. The resulting rate, expressed as a percentage, is levied against the premium paid by each employer enrolled under compensation plan No. 2 or plan No. 3 in the next fiscal year.

(c) On or before April 30, 2001, and on each succeeding April 30, the department, in consultation with the advisory organization designated pursuant to 33-16-1023, shall notify plan No. 2 insurers and plan No. 3, the state fund, of the premium surcharge percentage to be effective for policies written or renewed annually on and after July 1 of that year.

(d) The premium surcharge must be paid whenever the employer pays a premium to the insurer. Each insurer shall collect the premium surcharge levied against every employer that it insures. Each insurer shall pay to the department all money collected as a premium surcharge within 20 days of the end of the calendar quarter in which the money was collected. If an insurer fails to timely pay to the department the premium surcharge collected under this section, the department may impose on the insurer an administrative fine of $500 plus interest on the delinquent amount at the annual interest rate of 12%. Administrative fines and interest must be

deposited in the workers' compensation administration fund.

(e) If an employer fails to remit to an insurer the total amount due for the premium and premium surcharge, the amount received by the insurer must be applied to the premium surcharge first and the remaining amount applied to the premium due.

(f) The amount actually collected as a premium surcharge in a given year must be compared to the 3% of paid losses paid in the preceding year. Any amount collected in excess of the 3% must be deducted from the amount to be collected as a premium surcharge in the following year. The amount collected that is less than the 3% must be added to the amount to be collected as a premium surcharge in the following year.

(8) On or before April 30~~, 2001, and on~~ of each ~~succeeding April 30~~ year, upon a determination by the department, an insurer under compensation plan No. 2 that pays benefits in the preceding calendar year but that will not collect any premium for coverage in the following fiscal year shall pay an assessment equal to 3% of paid losses paid in the preceding calendar year, subject to a minimum assessment of $500, that is due on July 1.

(9) An employer that makes a first-time application for permission to enroll under compensation plan No. 1 shall pay an assessment of $500 within 15 days of being granted permission by the department to enroll under compensation plan No. 1.

(10) The department shall deposit all funds received pursuant to this section in the state treasury, as provided in this section.

(11) The administration fund must be debited with expenses incurred by the department in the general administration of the provisions of this chapter, including the salaries of its members, officers, and employees and the travel expenses of the members, officers, and employees, as provided for in 2-18-501 through 2-18-503, incurred while on the business of the department either within or without the state.

(12) Disbursements from the administration money must be made after being approved by the department upon claim for disbursement.

(13) The department may assess and collect the workers' compensation regulatory assessment surcharge from uninsured employers, as defined in 39-71-501, that fail to properly comply with the coverage requirements of the Workers' Compensation Act ~~and the Occupational Disease Act of Montana~~. Any amounts collected by the department pursuant to this subsection must be deposited in the workers' compensation administration fund."

Section 14. Section 39-71-206, MCA, is amended to read:

"39-71-206. Legal advisers of department and state fund -- investigative and prosecution services. (1) The attorney general is the legal adviser of the department and the state fund and shall represent either entity in all proceedings if requested by the department or state fund. The department and state fund may employ other attorneys or legal advisers as they consider necessary.

(2) As provided in 2-15-2015, the attorney general shall provide investigative and prosecution services to the state fund with respect to violations of ~~Title 39, chapters~~ this chapter ~~71 and 72~~."

Section 15. Section 39-71-211, MCA, is amended to read:

"39-71-211. Fraud detection and prevention unit -- expenditure accounting. (1) The state fund shall establish a fraud prevention and detection unit. The unit is responsible for developing detection and prevention procedures, providing detection services, and providing training in the prevention and detection of fraudulent conduct under Title 39, ~~chapters~~ chapter 71 ~~and 72~~, that is subject to prosecution under Title 45. The unit shall refer all cases of suspected fraudulent conduct to the workers' compensation fraud investigation and prosecution office established in 2-15-2015.

(2) The state fund shall expend money to investigate fraud pursuant to this section and shall separately account for money expended."

Section 16. Section 39-71-315, MCA, is amended to read:

"39-71-315. Prohibited actions -- penalty. (1) The following actions by a medical provider constitute violations and are subject to the penalty in subsection (2):

(a) failing to document, under oath, the provision of the services or treatment for which compensation is claimed under ~~chapter 72 or~~ this chapter; or

(b) referring a worker for treatment or diagnosis of an injury or illness that is compensable under ~~chapter 72 or~~ this chapter to a facility owned wholly or in part by the provider, unless the provider informs the worker of the ownership interest and provides the name and address of alternate facilities, if any exist.

(2) A person who violates this section may be assessed a penalty of not less than $200 or more than $500 for each offense. The department shall assess and collect the penalty. Penalties collected pursuant to this section must be paid into the state general fund. The workers' compensation court has jurisdiction over actions brought to collect the penalty and over disputes concerning the penalty assessment. Disputes brought pursuant to this section are not subject to mediation.

(3) Subsection (1)(b) does not apply to medical services provided to an injured worker by a treating physician with an ownership interest in a managed care organization that has been certified by the department."

Section 17. Section 39-71-316, MCA, is amended to read:

"39-71-316. Filing true claim -- obtaining benefits through deception or other fraudulent means. (1) A person filing a claim under ~~chapter 72 or~~ this chapter, by signing the claim, affirms the information filed is true and correct to the best of that person's knowledge.

(2) (a) A person who obtains or assists in obtaining benefits to which the person is not entitled or who obtains or assists another person in obtaining benefits to which the other person is not entitled under ~~chapter 72 or~~ this chapter is guilty of theft and may be prosecuted under 45-6-301. A county attorney or the attorney general may initiate criminal proceedings against the person. This subsection includes but is not limited to a person who is receiving temporary total disability benefits, permanent total disability benefits, or rehabilitation benefits while working without the knowledge and concurrence of the insurer.

(b) As used in subsection (2)(a), "person" includes but is not limited to an employee, employer, insurer, or medical service provider.

(3) (a) The department may require a person convicted of theft under 45-6-301(5) to pay to the department an amount equal to 10 times the amount paid by an insurer on the false claim, provided that the amount does not exceed $50,000. If upon demand of the department the person refuses to pay the fine, the department may petition the workers' compensation court to collect the money owed.

(b) The department shall:

(i) use the money collected pursuant to subsection (3)(a) to administer and enforce the provisions of this section; and

(ii) forward any surplus money to the department of justice. The forwarded money must be used exclusively for the staffing and operation of the workers' compensation fraud investigation and prosecution office established in 2-15-2015.

(c) This section does not limit an insurer's civil remedies to collect for money paid to a person convicted under 45-6-301(5).

(4) A person licensed under the provisions of Title 37 is subject to suspension, revocation, or denial of a license if the person knowingly claims or assists in the claiming of benefits in violation of the provisions of ~~chapter 72 or~~ this chapter."

Section 18. Section 39-71-317, MCA, is amended to read:

"39-71-317. Employer not to terminate worker for filing claim -- preference -- jurisdiction over dispute. (1) An employer may not use as grounds for terminating a worker the filing of a claim under ~~chapter 72 or~~ this chapter. The district court has exclusive jurisdiction over disputes concerning the grounds for termination under this section.

(2) When an injured worker is capable of returning to work within 2 years from the date of injury and has received a medical release to return to work, the worker must be given a preference over other applicants for a comparable position that becomes vacant if the position is consistent with the worker's physical condition and vocational abilities.

(3) This preference applies only to employment with the employer for whom the employee was working at the time the injury occurred.

(4) The workers' compensation court has exclusive jurisdiction to administer or resolve a dispute concerning the reemployment preference under this section. A dispute concerning the reemployment preference is not subject to mediation or a contested case hearing."

Section 19. Section 39-71-403, MCA, is amended to read:

"39-71-403. Plan three exclusive for state agencies -- election of plan by public corporations -- financing of self-insurance fund -- exemption for university system -- definition. (1) Except as provided in subsection (5), if a state agency is the employer, the terms, conditions, and provisions of compensation plan No. 3, state fund, are exclusive, compulsory, and obligatory upon both employer and employee. Any sums necessary to be paid under the provisions of this chapter by a state agency are considered to be ordinary and necessary expenses of the agency. The agency shall ~~make appropriation of and~~ pay the sums into the state fund at the time and in the manner provided for in this chapter, notwithstanding that the state agency may have failed to anticipate the ordinary and necessary expense in a budget, estimate of expenses, appropriations, ordinances, or otherwise.

(2) A public corporation, other than a state agency, may elect coverage under compensation plan No. 1, plan No. 2, or plan No. 3, separately or jointly with any other public corporation, other than a state agency. A public corporation electing compensation plan No. 1 may purchase reinsurance or issue bonds or notes pursuant to subsection (3)(b). A public corporation electing compensation plan No. 1 is subject to the same provisions as

a private employer electing compensation plan No. 1.

(3) (a) A public corporation, other than a state agency, that elects plan No. 1 may establish a fund sufficient to pay the compensation and benefits provided for in ~~chapter 72 and~~ this chapter and to discharge all liabilities that are reasonably incurred during the fiscal year for which the election is effective. Proceeds from the fund must be used only to pay claims covered by ~~chapter 72 and~~ this chapter and for actual and necessary expenses required for the efficient administration of the fund, including debt service on any bonds and notes issued pursuant to subsection (3)(b).

(b) (i) A public corporation, other than a state agency, separately or jointly with another public corporation, other than a state agency, may issue and sell its bonds and notes for the purpose of establishing, in whole or in part, the self-insurance workers' compensation fund provided for in subsection (3)(a) and to pay the costs associated with the sale and issuance of the bonds. Bonds and notes may be issued in an amount not exceeding 0.18% of the total assessed value of taxable property, determined as provided in 15-8-111, of the public corporation as of the date of issue. The bonds and notes must be authorized by resolution of the governing body of the public corporation and are payable from an annual property tax levied in the amount necessary to pay principal and interest on the bonds or notes. This authority to levy an annual property tax exists despite any provision of law or maximum levy limitation, including 15-10-420, to the contrary. The revenue derived from the sale of the bonds and notes may not be used for any other purpose.

(ii) The bonds and notes:

(A) may be sold at public or private sale;

(B) do not constitute debt within the meaning of any statutory debt limitation; and

(C) may contain other terms and provisions that the governing body determines.

(iii) Two or more public corporations, other than state agencies, may agree to exercise their respective borrowing powers jointly under this subsection (3)(b) or may authorize a joint board to exercise the powers on their behalf.

(iv) The fund established from the proceeds of bonds and notes issued and sold under this subsection (3)(b) may, if sufficient, be used in lieu of a surety bond, reinsurance, specific and aggregate excess insurance, or any other form of additional security necessary to demonstrate the public corporation's ability to discharge all liabilities as provided in subsection (3)(a). Subject to the total assessed value limitation in subsection (3)(b)(i), a public corporation may issue bonds and notes to establish a fund sufficient to discharge liabilities for periods greater than 1 year.

(4) All money in the fund established under subsection (3)(a) not needed to meet immediate expenditures must be invested by the governing body of the public corporation or the joint board created by two or more public corporations as provided in subsection (3)(b)(iii), and all proceeds of the investment must be credited to the fund.

(5) The provisions of subsection (1) do not apply to the Montana university system.

(6) As used in subsections (2) through (4), "public corporation" includes the Montana university system."

Section 20. Section 39-71-407, MCA, is amended to read:

"39-71-407. Liability of insurers -- limitations. (1) ~~Each~~ For workers' compensation injuries, each insurer is liable for the payment of compensation, in the manner and to the extent provided in this section, to an employee of an employer covered under plan No. 1, plan No. 2, and the state fund under plan No. 3 that it insures who receives an injury arising out of and in the course of employment or, in the case of death from the injury, to the employee's beneficiaries, if any.

(2) (a) An insurer is liable for an injury, as defined in 39-71-119, if the injury is established by objective medical findings and if the claimant establishes that it is more probable than not that:

(i) a claimed injury has occurred; or

(ii) a claimed injury aggravated a preexisting condition.

(b) Proof that it was medically possible that a claimed injury occurred or that the claimed injury aggravated a preexisting condition is not sufficient to establish liability.

(3) (a) An employee who suffers an injury or dies while traveling is not covered by this chapter unless:

(i) the employer furnishes the transportation or the employee receives reimbursement from the employer for costs of travel, gas, oil, or lodging as a part of the employee's benefits or employment agreement and the travel is necessitated by and on behalf of the employer as an integral part or condition of the employment; or

(ii) the travel is required by the employer as part of the employee's job duties.

(b) A payment made to an employee under a collective bargaining agreement, personnel policy manual, or employee handbook or any other document provided to the employee that is not wages but is designated as an incentive to work at a particular jobsite is not a reimbursement for the costs of travel, gas, oil, or lodging, and the employee is not covered under this chapter while traveling.

(4) An employee is not eligible for benefits otherwise payable under this chapter if the employee's use of alcohol or drugs not prescribed by a physician is the major contributing cause of the accident. However, if the

employer had knowledge of and failed to attempt to stop the employee's use of alcohol or drugs, this subsection does not apply.

(5) If a claimant who has reached maximum healing suffers a subsequent nonwork-related injury to the same part of the body, the workers' compensation insurer is not liable for any compensation or medical benefits caused by the subsequent nonwork-related injury.

(6) An employee is not eligible for benefits payable under this chapter unless the entitlement to benefits is established by objective medical findings that contain sufficient factual and historical information concerning the relationship of the worker's condition to the original injury.

(7) For occupational diseases, every employer enrolled under plan No. 1, every insurer under plan No. 2, or the state fund under plan No. 3 is liable for the payment of compensation, in the manner and to the extent provided in this chapter, to an employee of an employer covered under plan No. 1, plan No. 2, or the state fund under plan No. 3 with an occupational disease that arises out of or is contracted in the course and scope of employment.

(8) Occupational diseases are considered to arise out of employment or be contracted in the course and scope of employment if:

(a) the occupational disease is established by objective medical findings; and

(b) the events occurring on more than a single day or work shift are ~~more than 50% responsible for~~ THE MAJOR CONTRIBUTING CAUSE OF the occupational disease in relation to other factors contributing to the occupational disease.

(9) When compensation is payable for an occupational disease, the only employer liable is the employer in whose employment the employee was last injuriously exposed to the hazard of the disease.

(10) When there is more than one insurer and only one employer at the time that the employee was injuriously exposed to the hazard of the disease, the liability rests with the insurer providing coverage at the earlier of:

(a) the time that the occupational disease was first diagnosed by a treating physician or medical panel; or

(b) the time that the employee knew or should have known that the condition was the result of an occupational disease.

(11) In the case of pneumoconiosis, any coal mine operator who has acquired a mine in the state or substantially all of the assets of a mine from a person who was an operator of the mine on or after December

30, 1969, is liable for and shall secure the payment of all benefits that would have been payable by that person with respect to miners previously employed in the mine if acquisition had not occurred and that person had continued to operate the mine, and the prior operator of the mine is not relieved of any liability under this section.

~~(7)~~(12) As used in this section, "major contributing cause" means a cause that is the leading cause contributing to the result when compared to all other contributing causes."

Section 21. Section 39-71-416, MCA, is amended to read:

"39-71-416. Benefit reduction for third-party recovery. (1) If an employee is injured or dies and obtains a third-party recovery, settlement, or award, an insurer may reduce by 30% the benefits paid or that are required to be paid to the employee or beneficiary pursuant to this chapter ~~71 or 72~~ as a result of the injury or death. The reduction applies to any recovery, settlement, or award regardless of the form of action or the nature of damages. The total of any reductions may not exceed 30% of any third-party recovery, settlement, or award.

(2) This section does not limit or prohibit an insurer's right to pursue subrogation pursuant to 39-71-414.

(3) If an insurer is entitled to subrogation pursuant to 39-71-414, the amount subrogated must be offset by any reduction in benefits pursuant to subsection (1)."

Section 22. Section 39-71-525, MCA, is amended to read:

"39-71-525. Confidentiality of records -- exception for use by public employees. Information obtained from any individual under this part is confidential and may not be disclosed, sold, or opened to public inspection except to department employees when necessary to allow them to perform their public duties under Title 39, ~~chapters~~ chapter 71 ~~and 72~~, or to provide relevant and necessary information to other public entities or pursuant to a subpoena issued upon a showing of compelling state interest."

Section 23. Section 39-71-601, MCA, is amended to read:

"39-71-601. Statute of limitation on presentment of claim -- waiver. (1) ~~In case of personal injury or death~~ Except for a claim for benefits for occupational diseases pursuant to subsections (3) and (4), all claims in the case of personal injury or death must be forever barred unless signed by the claimant or the claimant's representative and presented in writing to the employer, the insurer, or the department, as the case may be, within 12 months from the date of the happening of the accident, either by the claimant or someone legally authorized to act on the claimant's behalf.

(2) The insurer may waive the time requirement up to an additional 24 months upon a reasonable showing by the claimant of:

(a) lack of knowledge of disability;

(b) latent injury; or

(c) equitable estoppel.

(3) When a claimant seeks benefits for an occupational disease, the claimant's claims for benefits must be presented in writing to the employer, the employer's insurer, or the department within 1 year from the date that the claimant knew or should have known that the claimant's condition resulted from an occupational disease. When a beneficiary seeks benefits under this chapter, claims for death benefits must be presented in writing to the employer, the employer's insurer, or the department within 1 year from the date that the beneficiary knew or should have known that the decedent's death was related to an occupational disease.

~~(3)~~(4) Any dispute regarding the statute of limitations for filing time is considered a dispute that, after mediation pursuant to department rules, is subject to jurisdiction of the workers' compensation court."

Section 24. Section 39-71-603, MCA, is amended to read:

"39-71-603. Notice of injuries other than death to be submitted within thirty days -- exception. (1) A claim to recover benefits under the Workers' Compensation Act for injuries not resulting in death may not be considered compensable unless, within 30 days after the occurrence of the accident that is claimed to have caused the injury, notice of the time and place where the accident occurred and the nature of the injury is given to the employer or the employer's insurer by the injured employee or someone on the employee's behalf. Actual knowledge of the accident and injury on the part of the employer or the employer's managing agent or superintendent in charge of the work in which the injured employee was engaged at the time of the injury is equivalent to notice.

(2) If a sole proprietor, partner, manager of a manager-managed limited liability company, member of a member-managed limited liability company, or corporate officer covered under this chapter is injured in an accident, the sole proprietor, partner, manager, member, or corporate officer or an appointed designee shall, within 30 days, notify the insurer of the time and location of the accident and the nature of the injury.

(3) This section does not apply to occupational diseases."

Section 25. Section 39-71-612, MCA, is amended to read:

"39-71-612. Costs and attorney fees that may be assessed against insurer by workers' compensation judge -- barring of attorney fees under common fund or other doctrines. (1) If an insurer pays or submits a written offer of payment of compensation under this chapter ~~71 or 72 of this title~~ but controversy relates to the amount of compensation due, the case is brought before the workers' compensation judge for adjudication of the controversy, and the award granted by the judge is greater than the amount paid or offered by the insurer, reasonable attorney fees and costs as established by the workers' compensation judge if the case has gone to a hearing may be awarded by the judge in addition to the amount of compensation.

(2) An award of attorney fees under subsection (1) may be made only if it is determined that the actions of the insurer were unreasonable. Any written offer of payment made 30 days or more before the date of hearing must be considered a valid offer of payment for the purposes of this section.

(3) A finding of unreasonableness against an insurer made under this section does not constitute a finding that the insurer acted in bad faith or violated the unfair trade practices provisions of Title 33, chapter 18.

(4) Attorney fees may be awarded only under the provisions of subsections (1) and (2) and may not be awarded under the common fund doctrine or any other action or doctrine in law or equity."

Section 26. Section 39-71-743, MCA, is amended to read:

"39-71-743. Assignment or attachment of payments. (1) Payments under this chapter may not be assignable, subject to attachment or garnishment, or held liable in any way for debts, except:

(a) as provided in 71-3-1118;

(b) a portion of any lump-sum award or periodic payment to pay a monetary obligation for current or past-due child support, subject to the limitations in subsection (2), whenever the support obligation is established by order of a court of competent jurisdiction or by order rendered in an administrative process authorized by state law; or

(c) as provided in 53-2-612 or 53-2-613 for medical benefits paid pursuant to ~~chapter 71 or 72 of~~ this ~~title~~ chapter.

(2) Payments under this chapter are subject to assignment, attachment, or garnishment for child support as follows:

(a) for any periodic payment, an amount up to the percentage amount established in the guidelines promulgated by the department of public health and human services pursuant to 40-5-209; or

(b) for any lump-sum award, an amount up to that portion of the award that is approved for payment

on the basis of a past-due child support obligation.

(3) After determination that the claim is covered under the Workers' Compensation Act ~~or Occupational Disease Act of Montana~~, the liability for payment of the claim is the responsibility of the appropriate workers' compensation insurer. Except as provided in 39-71-704(7), a fee or charge is not payable by the injured worker for treatment of injuries sustained if liability is accepted by the insurer."

Section 27. Section 39-71-915, MCA, is amended to read:

"39-71-915. Assessment of insurer -- employers -- definition -- collection. (1) As used in this section, "paid losses" means the following benefits paid during the preceding calendar year for injuries covered by the ~~Montana~~ Workers' Compensation Act ~~and the Occupational Disease Act of Montana~~ without regard to the application of any deductible, regardless of whether the employer or the insurer pays the losses:

(a) total compensation benefits paid; and

(b) except for medical benefits in excess of $200,000 for each occurrence that are exempt from assessment, total medical benefits paid for medical treatment rendered to an injured worker, including hospital treatment and prescription drugs.

(2) The fund must be maintained by assessing each plan No. 1 employer, each employer insured by a plan No. 2 insurer, plan No. 3, the state fund, with respect to claims arising before July 1, 1990, and each employer insured by plan No. 3, the state fund. The assessment amount is the total amount of paid losses reimbursed from the fund in the preceding calendar year and the expenses of administration less other income. The total assessment amount to be collected must be allocated among plan No. 1 employers, plan No. 2 employers, plan No. 3, the state fund, and plan No. 3 employers, based on a proportionate share of paid losses for the calendar year preceding the year in which the assessment is collected. The board of investments shall invest the money of the fund, and the investment income must be deposited in the fund.

(3) On or before May 31 each year, the department shall notify each plan No. 1 employer, plan No. 2 insurer, and plan No. 3, the state fund, of the amount to be assessed for the ensuing fiscal year. The amount to be assessed against the state fund must separately identify the amount attributed to claims arising before July 1, 1990, and the amount attributable to state fund claims arising on or after July 1, 1990. On or before April 30 each year, the department, in consultation with the advisory organization designated under 33-16-1023, shall notify plan No. 2 insurers and plan No. 3 of the premium surcharge rate to be effective for policies written or renewed on and after July 1 in that year.

(4) The portion of the plan No. 1 assessment assessed against an individual plan No. 1 employer is a proportionate amount of total plan No. 1 paid losses during the preceding calendar year that is equal to the percentage that the total paid losses of the individual plan No. 1 employer bore to the total paid losses of all plan No. 1 employers during the preceding calendar year.

(5) The portion of the assessment attributable to state fund claims arising before July 1, 1990, is the proportionate amount that is equal to the percentage that total paid losses for those claims during the preceding calendar year bore to the total paid losses for all plans in the preceding calendar year. As required by 39-71-2352, the state fund may not pass along to insured employers the cost of the subsequent injury fund assessment that is attributable to claims arising before July 1, 1990.

(6) The remaining portion of the assessment must be paid by way of a surcharge on premiums paid by employers being insured by a plan No. 2 insurer or plan No. 3, the state fund, for policies written or renewed annually on or after July 1. The surcharge rate must be computed by dividing the remaining portion of the assessment by the total amount of premiums paid by employers insured under plan No. 2 or plan No. 3 in the previous calendar year. The numerator for the calculation must be adjusted as provided by subsection (9).

(7) Each plan No. 2 insurer providing workers' compensation insurance and plan No. 3, the state fund, shall collect from its policyholders the assessment premium surcharge provided for in subsection (6). When collected, the assessment premium surcharge may not constitute an element of loss for the purpose of establishing rates for workers' compensation insurance but, for the purpose of collection, must be treated as separate costs imposed upon insured employers. The total of this assessment premium surcharge must be stated as a separate cost on an insured employer's policy or on a separate document submitted by the insured employer and must be identified as "workers' compensation subsequent injury fund surcharge". Each assessment premium surcharge must be shown as a percentage of the total workers' compensation policyholder premium. This assessment premium surcharge must be collected at the same time and in the same manner that the premium for the coverage is collected. The assessment premium surcharge must be excluded from the definition of premiums for all purposes, including computation of insurance producers' commissions or premium taxes, except that an insurer may cancel a workers' compensation policy for nonpayment of the assessment premium surcharge. Cancellation must be in accordance with the procedures applicable to the nonpayment of premium. If an employer fails to remit to an insurer the total amount due for the premium and assessment premium surcharge, the amount received by the insurer must be applied to the assessment premium surcharge first and the remaining amount applied to the premium due.

(8) (a) All assessments paid to the department must be deposited in the fund.

(b) Each plan No. 1 employer shall pay its assessment by July 1.

(c) Each plan No. 2 insurer and plan No. 3, the state fund, shall remit to the department all assessment premium surcharges collected during a calendar quarter by not later than 20 days following the end of the quarter.

(d) The state fund shall pay the portion of the assessment attributable to claims arising before July 1, 1990, by July 1.

(e) If a plan No. 1 employer, a plan No. 2 insurer, or plan No. 3, the state fund, fails to timely pay to the department the assessment or assessment premium surcharge under this section, the department may impose on the plan No. 1 employer, the plan No. 2 insurer, or plan No. 3, the state fund, an administrative fine of $100 plus interest on the delinquent amount at the annual interest rate of 12%. Administrative fines and interest must be deposited in the fund.

(9) The amount of the assessment premium surcharge actually collected pursuant to subsection (7) must be compared each year to the amount assessed and upon which the premium surcharge was calculated. The amount undercollected or overcollected in any given year must be used as an adjustment to the numerator provided for by subsection (6) for the following year's assessment premium surcharge."

Section 28. Section 39-71-1105, MCA, is amended to read:

"39-71-1105. Managed care organizations -- application -- certification. (1) A health care provider, a group of medical service providers, or an entity with a managed care organization may make written application to the department to become certified under this section to provide managed care to ~~injured~~ workers for injuries or occupational diseases that are covered under this chapter ~~or for occupational diseases that are covered under the Occupational Disease Act of Montana~~. However, this section does not authorize an organization that is formed, owned, or operated by a workers' compensation insurer or self-insured employer other than a health care provider to become certified to provide managed care. When a health care provider, a group of medical service providers, or an entity with a managed care organization is establishing a managed care organization and independent physical therapy practices exist in the community, the managed care organization is encouraged to utilize independent physical therapists as part of the managed care organization if the independent physical therapists agree to abide by all the applicable requirements for a managed care organization set forth in this section, in rules established by the department, and in the provisions of a managed

care plan for which certification is being sought.

(2) Each application for certification must be accompanied by an application fee if prescribed by the department. A certificate is valid for the period prescribed by the department, unless it is revoked or suspended at an earlier date.

(3) The department shall establish by rule the form for the application for certification and the required information regarding the proposed plan for providing medical services. The information includes but is not limited to:

(a) a list of names of each individual who will provide services under the managed care plan, together with appropriate evidence of compliance with any licensing or certification requirements for that individual to practice in the state;

(b) names of the individuals who will be designated as treating physicians and who will be responsible for the coordination of medical services;

(c) a description of the times, places, and manner of providing primary medical services under the plan;

(d) a description of the times, places, and manner of providing secondary medical services, if any, that the applicants wish to provide; and

(e) satisfactory evidence of the ability to comply with any financial requirements to ensure delivery of service in accordance with the plan that the department may require.

(4) The department shall certify a group of medical service providers or an entity with a managed care organization to provide managed care under a plan if the department finds that the plan:

(a) proposes to provide coordination of services that meet quality, continuity, and other treatment standards prescribed by the department and will provide all primary medical services that may be required by this chapter in a manner that is timely and effective for the worker;

(b) provides appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of services;

(c) provides adequate methods of peer review and service utilization review to prevent excessive or inappropriate treatment, to exclude from participation in the plan those individuals who violate these treatment standards, and to provide for the resolution of any medical disputes that may arise;

(d) provides for cooperative efforts by the worker, the employer, the rehabilitation providers, and the managed care organization to promote an early return to work for the injured worker;

(e) provides a timely and accurate method of reporting to the department necessary information

regarding medical and health care service cost and utilization to enable the department to determine the effectiveness of the plan;

(f) authorizes workers to receive medical treatment from a primary care physician who is not a member of the managed care organization but who maintains the worker's medical records and with whom the worker has a documented history of treatment, if that primary care physician agrees to refer the worker to the managed care organization for any specialized treatment, including physical therapy, that the worker may require and if that primary care physician agrees to comply with all the rules, terms, and conditions regarding services performed by the managed care organization. As used in this subsection (4)(f), "primary care physician" means a physician who is qualified to be a treating physician and who is a family practitioner, a general practitioner, an internal medicine practitioner, or a chiropractor.

(g) complies with any other requirements determined by department rule to be necessary to provide quality medical services and health care to injured workers.

(5) The department shall refuse to certify or may revoke or suspend the certification of a health care provider, a group of medical service providers, or an entity with a managed care organization to provide managed care if the department finds that:

(a) the plan for providing medical care services fails to meet the requirements of this section; and

(b) service under the plan is not being provided in accordance with the terms of a certified plan."

Section 29. Section 39-71-2401, MCA, is amended to read:

"39-71-2401. Disputes -- jurisdiction -- settlement requirements -- mediation. (1) A dispute concerning benefits arising under this chapter ~~or chapter 72~~, other than the disputes described in subsection (2), must be brought before a department mediator as provided in this part. If a dispute still exists after the parties satisfy the mediation requirements in this part, either party may petition the workers' compensation court for a resolution.

(2) A dispute arising under this chapter that does not concern benefits or a dispute for which a specific provision of this chapter gives the department jurisdiction must be brought before the department.

(3) An appeal from a department order may be made to the workers' compensation court.

(4) Except as otherwise provided in this chapter, before a party may bring a dispute concerning benefits before a mediator, the parties shall attempt to settle as follows:

(a) The party making a demand shall present the other party with a specific written demand that

contains sufficient explanation and documentary evidence to enable the other party to thoroughly evaluate the demand.

(b) The party receiving the demand shall respond in writing within 15 working days of receipt. If the demand is denied in whole or in part, the response shall state the basis of the denial.

(c) Upon motion of a party or upon the mediator's own motion, the mediator has the authority to dismiss a petition if he finds that either party did not comply with this subsection. A decision dismissing a petition under this subsection must be in writing and must state in detail the grounds for dismissal. The mediator's decision may be reviewed by the workers' compensation court upon motion of a party.

(d) Nothing in this subsection relieves a party of an obligation otherwise contained in this chapter."

Section 30. Section 39-71-2406, MCA, is amended to read:

"39-71-2406. Purpose. The purpose of this part is to prevent when possible the filing in the workers' compensation court of actions by claimants or insurers relating to claims under ~~chapter 71 or 72 of~~ this ~~title~~ chapter if an equitable and reasonable resolution of the dispute may be effected at an earlier stage. To achieve this purpose, this part provides for a procedure for mandatory, nonbinding mediation. It is the intent of this part that the mediation process be used to resolve cases on an informal basis at minimal cost to the parties, and to this end, the parties are required to fully present their cases at the mediation level. However, if a cause proceeds to the workers' compensation court, the parties are not precluded from presenting additional evidence before the court. If a new issue is raised at the workers' compensation court that was not raised at mediation, the court shall remand the issue to the mediator for consideration."

Section 31. Section 39-71-2408, MCA, is amended to read:

"39-71-2408. Mandatory, nonbinding mediation. (1) Except as otherwise provided, in a dispute arising under ~~chapter 71 or 72 of~~ this ~~title~~ chapter, the insurer and claimant shall mediate any issue concerning benefits and the mediator shall issue a report following the mediation process recommending a solution to the dispute before either party may file a petition in the workers' compensation court.

(2) The resolution recommended by the mediator is without administrative or judicial authority and is not binding on the parties."

Section 32. Section 39-71-2411, MCA, is amended to read:

"39-71-2411. Mediation procedure. (1) Except as otherwise provided, a claimant or an insurer having a dispute relating to benefits under ~~chapter 71 or 72 of~~ this ~~title~~ chapter may petition the department for mediation of the dispute.

(2) A party may take part in mediation proceedings with or without representation.

(3) The mediator shall review the department file for the case and may receive any additional documentation or argument either party submits.

(4) The mediator shall request that each party offer argument summarizing the party's position. A party's argument must fully present the party's case. The argument is not limited by the rules of evidence.

(5) After the parties have presented all their information and argument to the mediator, the mediator shall recommend a solution to the parties within a reasonable time to be established by rule.

(6) A party shall notify the mediator within 25 days of the mailing of the mediator's report whether the party accepts the mediator's recommendation. If either party does not accept the mediator's recommendation, the party may petition the workers' compensation court for resolution of the dispute.

(7) (a) If a mediator determines that either party failed to cooperate in the mediation process, the mediator shall prepare a written report setting forth the determination and the grounds for the determination. The report must be mailed to the parties and to the workers' compensation court. Unless a party disputes the determination as set forth in subsection (7)(c), the parties shall repeat the mediation process, but only one time.

(b) A mediator may determine that a party has failed to cooperate in the mediation process only if the party failed to:

(i) supply information or offer a summary of the party's position as reasonably requested by the mediator;

(ii) attend scheduled mediation conferences unless excused by the mediator; or

(iii) listen to and review the information and position offered by the opposing party.

(c) If a party disputes a mediator's determination that the party failed to cooperate in the mediation process, the party may file a petition with the workers' compensation court. Upon receipt of a petition, the court shall summon the parties and the mediator to determine by oral discussion whether the mediator's determination of noncooperation is supportable. If the court finds that the mediator's determination is supportable, the court may order the parties to attempt a second time to mediate their dispute."

Section 33. Section 39-73-104, MCA, is amended to read:

"39-73-104. Eligibility requirements for benefits. Payment ~~shall~~ must be made under this chapter to any person who:

(1) has silicosis, as defined in 39-73-101, ~~which~~ that results in ~~his~~ the person's total disability so as to render it impossible for ~~him~~ the person to follow continuously any substantially gainful occupation;

(2) has resided in and been an inhabitant of the state of Montana for 10 years or more immediately preceding the date of the application;

(3) is not receiving, with respect to any month for which ~~he~~ the person would receive a payment under this chapter, compensation under ~~The Occupational Disease Act of Montana, as provided by chapter 72 of this title~~ [section 4], which will equal the sum of $200."

Section 34. Section 39-73-107, MCA, is amended to read:

"39-73-107. Amount of payments. Subject to the provisions of this chapter and the deductions provided in this chapter, any person who has silicosis and who has, subject to the regulations and standards of the department of labor and industry, been determined by the department to be entitled payment under this chapter for silicosis must be granted a payment by the department of $250 a month, subject to any additional appropriations. If the person is receiving payments under ~~the Occupational Disease Act of Montana, as provided by chapter 72 of this title,~~ [section 4] that are less in the aggregate than $200, then the person is entitled to a payment under this chapter of the difference between the amount received under ~~the Occupational Disease Act of Montana, as provided by chapter 72 of this title~~ [section 4]~~,~~ and $250 a month. The legislature shall authorize additional appropriations that may be necessary to make the increased monthly payments provided in this section."

Section 35. Section 45-6-301, MCA, is amended to read:

"45-6-301. Theft. (1) A person commits the offense of theft when the person purposely or knowingly obtains or exerts unauthorized control over property of the owner and:

(a) has the purpose of depriving the owner of the property;

(b) purposely or knowingly uses, conceals, or abandons the property in a manner that deprives the owner of the property; or

(c) uses, conceals, or abandons the property knowing that the use, concealment, or abandonment probably will deprive the owner of the property.

(2) A person commits the offense of theft when the person purposely or knowingly obtains by threat or deception control over property of the owner and:

(a) has the purpose of depriving the owner of the property;

(b) purposely or knowingly uses, conceals, or abandons the property in a manner that deprives the owner of the property; or

(c) uses, conceals, or abandons the property knowing that the use, concealment, or abandonment probably will deprive the owner of the property.

(3) A person commits the offense of theft when the person purposely or knowingly obtains control over stolen property knowing the property to have been stolen by another and:

(a) has the purpose of depriving the owner of the property;

(b) purposely or knowingly uses, conceals, or abandons the property in a manner that deprives the owner of the property; or

(c) uses, conceals, or abandons the property knowing that the use, concealment, or abandonment probably will deprive the owner of the property.

(4) A person commits the offense of theft when the person purposely or knowingly obtains or exerts unauthorized control over any part of any public assistance provided under Title 52 or 53 by a state or county agency, regardless of the original source of assistance, by means of:

(a) a knowingly false statement, representation, or impersonation; or

(b) a fraudulent scheme or device.

(5) A person commits the offense of theft when the person purposely or knowingly obtains or exerts or helps another obtain or exert unauthorized control over any part of any benefits provided under Title 39, chapter 71 ~~or 72~~, by means of:

(a) a knowingly false statement, representation, or impersonation; or

(b) deception or other fraudulent action.

(6) (a) A person commits the offense of theft when the person purposely or knowingly commits insurance fraud as provided in 33-1-1202 or 33-1-1302; or

(b) purposely or knowingly diverts or misappropriates insurance premiums as provided in 33-17-1102.

(7) A person commits the offense of theft of property by embezzlement when, with the purpose to deprive the owner of the property, the person:

(a) purposely or knowingly obtains or exerts unauthorized control over property of the person's employer

or over property entrusted to the person; or

(b) purposely or knowingly obtains by deception control over property of the person's employer or over property entrusted to the person.

(8) (a) A person convicted of the offense of theft of property not exceeding $1,000 in value shall be fined an amount not to exceed $1,000 or be imprisoned in the county jail for a term not to exceed 6 months, or both. A person convicted of a second offense shall be fined $1,000 or be imprisoned in the county jail for a term not to exceed 6 months, or both. A person convicted of a third or subsequent offense shall be fined $1,000 and be imprisoned in the county jail for a term of not less than 30 days or more than 6 months.

(b) Except as provided in subsection (8)(c), a person convicted of the offense of theft of property exceeding $1,000 in value or theft of any commonly domesticated hoofed animal shall be fined an amount not to exceed $50,000 or be imprisoned in a state prison for a term not to exceed 10 years, or both.

(c) A person convicted of the offense of theft of property exceeding $10,000 in value by embezzlement shall be imprisoned in a state prison for a term of not less than 1 year or more than 10 years and may be fined an amount not to exceed $50,000. The court may, in its discretion, place the person on probation with the requirement that restitution be made under terms set by the court. If the terms are not met, the required prison term may be ordered.

(9) Amounts involved in thefts committed pursuant to a common scheme or the same transaction, whether from the same person or several persons, may be aggregated in determining the value of the property."

Section 36. Section 71-3-1118, MCA, is amended to read:

"71-3-1118. Applicability. (1) Except as provided in subsection (2), this part does not apply to compensation awarded to workers for injury, disease, or death pursuant to the Workers' Compensation Act ~~or the Occupational Disease Act of Montana~~.

(2) This part applies to all payments awarded for medical, therapy, chiropractic, dentistry, counseling, and hospital services pursuant to the acts referred to in subsection (1).

(3) This part does not apply to any benefits payable under:

(a) a policy of life insurance or group life insurance;

(b) a contract of disability insurance, except benefits payable in reimbursement for services rendered by a physician, nurse, physical therapist, occupational therapist, chiropractor, dentist, psychologist, licensed social worker, licensed professional counselor, hospital, or ambulatory surgical facility; or

(c) an annuity contract or to pension benefits payable under a qualified pension plan."

Section 37. Section 85-5-101, MCA, is amended to read:

"85-5-101. Appointment of water commissioners. (1) Whenever the rights of persons to use the waters of any stream, ditch or extension of ditch, watercourse, spring, lake, reservoir, or other source of supply have been determined by a decree of a court of competent jurisdiction, including temporary preliminary, preliminary, and final decrees issued by a water judge, it is the duty of the judge of the district court having jurisdiction of the subject matter, upon the application of the owners of at least 15% of the water rights affected by the decree, in the exercise of the judge's discretion, to appoint one or more commissioners. The commissioners have authority to admeasure and distribute to the parties owning water rights in the source affected by the decree the waters to which they are entitled, according to their rights as fixed by the decree and by any certificates and permits issued under chapter 2 of this title. When petitioners make proper showing that they are not able to obtain the application of the owners of at least 15% of the water rights affected and they are unable to obtain the water to which they are entitled, the judge of the district court having jurisdiction may appoint a water commissioner.

(2) When the existing rights of all appropriators from a source or in an area have been determined in a temporary preliminary decree, preliminary decree, or final decree issued under chapter 2 of this title, the judge of the district court may, upon application by both the department of natural resources and conservation and one or more holders of valid water rights in the source, appoint a water commissioner. The water commissioner shall distribute to the appropriators, from the source or in the area, the water to which they are entitled.

(3) The department of natural resources and conservation or any person or corporation operating under contract with the department or any other owner of stored waters may petition the court to have stored waters distributed by the water commissioners appointed by the district court. The court may order the commissioner or commissioners appointed by the court to distribute stored water when and as released to water users entitled to the use of the water.

(4) At the time of the appointment of a water commissioner or commissioners, the district court shall fix their compensation, require a commissioner or commissioners to purchase a workers' compensation insurance policy and elect coverage on themselves, and require the owners and users of the distributed waters, including permittees and certificate holders, to pay their proportionate share of fees and compensation, including the cost of workers' compensation insurance purchased by a water commissioner or commissioners. The judge

may include the department in the apportionment of costs if it applied for the appointment of a water commissioner under subsection (2).

(5) Upon the application of the board or boards of one or more irrigation districts entitled to the use of water stored in a reservoir that is turned into the natural channel of any stream and withdrawn or diverted at a point downstream for beneficial use, the district court of the judicial district where the most irrigable acres of the irrigation district or districts are situated may appoint a water commissioner to equitably admeasure and distribute stored water to the irrigation district or districts from the channel of the stream into which it has been turned. A commissioner appointed under this subsection has the powers of any commissioner appointed under this chapter, limited only by the purposes of this subsection. A commissioner's compensation is set by the appointing judge and paid by each district and other users of stored water affected by the admeasurement and distribution of the stored water. In all other matters the provisions of this chapter apply so long as they are consistent with this subsection.

(6) A water commissioner appointed by a district court is not an employee of the judicial branch, a local government, or a water user.

(7) A water commissioner who fails to obtain workers' compensation insurance coverage required by subsection (4) is precluded from receiving benefits under Title 39, chapter 71 ~~or 72~~, as a result of the performance of duties as a water commissioner."

NEW SECTION. **Section 38. Repealer.** Sections 39-72-101, 39-72-102, 39-72-103, 39-72-201, 39-72-202, 39-72-203, 39-72-204, 39-72-206, 39-72-301, 39-72-302, 39-72-303, 39-72-305, 39-72-310, 39-72-401, 39-72-402, 39-72-403, 39-72-404, 39-72-405, 39-72-408, 39-72-509, 39-72-601, 39-72-602, 39-72-606, 39-72-607, 39-72-608, 39-72-701, 39-72-703, 39-72-704, 39-72-705, 39-72-706, 39-72-707, 39-72-708, 39-72-709, 39-72-711, 39-72-712, and 39-72-714, MCA, are repealed.

NEW SECTION. **Section 39. Codification instruction.** (1) [Section 1] is intended to be codified as an integral part of Title 39, chapter 71, part 1, and the provisions of Title 39, chapter 71, part 1, apply to [section 1].

(2) [Sections 2 through 5] are intended to be codified as an integral part of Title 39, chapter 71, part 7, and the provisions of Title 39, chapter 71, part 7, apply to [sections 2 through 5].

NEW SECTION. **Section 40. Coordination instruction.** If House Bill No. 126 is passed and approved and if it includes a section that repeals 39-71-416, then [section 21 of this act], amending 39-71-416, is void.

NEW SECTION. **Section 41. Direction to code commissioner.** The code commissioner is directed to change any reference to chapter 72 of Title 39 that appears in legislation enacted by the 2005 legislature to a reference to chapter 71 of Title 39.

NEW SECTION. **Section 42. Severability.** If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. **Section 43. Effective date -- applicability.** [This act] is effective July 1, 2005, and applies to occupational diseases that occur on or after July 1, 2005.

- END -

SENATE BILL NO. 481

INTRODUCED BY V. COCCHIARELLA

A BILL FOR AN ACT ENTITLED: "AN ACT MERGING OCCUPATIONAL DISEASES INTO THE WORKERS' COMPENSATION ACT; ESTABLISHING LEGISLATIVE INTENT TOWARD OCCUPATIONAL DISEASES AS PUBLIC POLICY; DEFINING "OCCUPATIONAL DISEASE"; PROVIDING FOR THE LIABILITY OF INSURERS AND COMPENSATION FOR OCCUPATIONAL DISEASES UNDER THE WORKERS' COMPENSATION ACT; PROVIDING FOR TIME FOR CLAIMS TO BE PRESENTED; AMENDING SECTIONS 2-15-2015, 30-9A-109, 37-1-131, 39-71-105, 39-71-106, 39-71-107, 39-71-116, 39-71-201, 39-71-206, 39-71-211, 39-71-315, 39-71-316, 39-71-317, 39-71-403, 39-71-407, 39-71-416, 39-71-525, 39-71-601, 39-71-603, 39-71-612, 39-71-743, 39-71-915, 39-71-1105, 39-71-2401, 39-71-2406, 39-71-2408, 39-71-2411, 39-73-104, 39-73-107, 45-6-301, 71-3-1118, AND 85-5-101, MCA; REPEALING SECTIONS 39-72-101, 39-72-102, 39-72-103, 39-72-201, 39-72-202, 39-72-203, 39-72-204, 39-72-206, 39-72-301, 39-72-302, 39-72-303, 39-72-305, 39-72-310, 39-72-401, 39-72-402, 39-72-403, 39-72-404, 39-72-405, 39-72-408, 39-72-509, 39-72-601, 39-72-602, 39-72-606, 39-72-607, 39-72-608, 39-72-701, 39-72-703, 39-72-704, 39-72-705, 39-72-706, 39-72-707, 39-72-708, 39-72-709, 39-72-711, 39-72-712, AND 39-72-714, MCA; AND PROVIDING AN EFFECTIVE DATE AND AN APPLICABILITY DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1. Applicability of workers' compensation act -- exceptions.** Except as provided in 39-71-407, 39-71-601, and 39-71-603, this chapter applies to injuries and occupational diseases.

NEW SECTION. **Section 2. Compensation for occupational diseases and medical benefits -- diminution of compensation.** (1) Compensation for occupational diseases must be equal to the compensation and medical benefits provided for injuries in this chapter.

(2) For an occupational disease, compensation payable to the claimant, the claimant's beneficiaries, or the claimant's dependents must be diminished by the amount of any compensation paid or to be paid to the claimant or the claimant's beneficiaries or dependents for the same condition for which benefits are received or may be claimed for an injury.

NEW SECTION. **Section 3. Autopsy.** Upon the filing of a claim for compensation for death caused by an occupational disease, if an autopsy is necessary to determine the cause of death, an autopsy may be requested by an insurer. The autopsy must be made under the supervision of the county coroner or a medical examiner. The expense of the autopsy must be paid by the insurer.

NEW SECTION. **Section 4. Benefits for pneumoconiosis.** (1) Pneumoconiosis is an occupational disease that is compensable under this part. However, any benefits granted a claimant under this chapter for pneumoconiosis must be reduced, but not below zero, by an amount equal to the benefits granted the claimant under any program under federal law that pays benefits for a claimant suffering disability from pneumoconiosis.

(2) "Pneumoconiosis" means a chronic dust disease of the lungs arising out of employment in coal mines and includes anthracosis, coal workers' pneumoconiosis, silicosis, or anthracosilicosis arising out of employment.

NEW SECTION. **Section 5. Prohibiting supplementing of benefits.** A person receiving compensation or benefits under chapter 73 of this title is not entitled to compensation or benefits under this chapter.

Section 6. Section 2-15-2015, MCA, is amended to read:

"2-15-2015. Workers' compensation fraud investigation and prosecution office. There is a workers' compensation fraud investigation and prosecution office in the department of justice. The office shall investigate and prosecute cases referred by the state compensation insurance fund or the department of labor and industry on behalf of the uninsured employers' fund. The office is under the supervision and control of the attorney general and consists of:

(1) one or more investigators qualified by education, training, experience, and high professional competence in investigative procedures who shall investigate violations of the provisions of Title 39, ~~chapters~~ chapter 71 ~~and 72~~, at the request of the state compensation insurance fund or the department of labor and industry on behalf of the uninsured employers' fund; and

(2) one or more attorneys licensed to practice law in Montana who shall prosecute violations of the provisions of Title 39, ~~chapters~~ chapter 71 ~~and 72~~. The attorneys may also assist county attorneys in prosecuting violations of Title 39, ~~chapters~~ chapter 71 ~~and 72~~, without charge to the county.

(3) The state compensation insurance fund, the department of labor and industry, and the department of justice shall submit to the legislature for approval one proposed biennial budget for the workers' compensation fraud office. The proposed budget for staffing and related expenses must be based upon the needs of the state

compensation insurance fund and the department of labor and industry on behalf of the uninsured employers' fund for investigating and prosecuting workers' compensation fraud."

Section 7. Section 30-9A-109, MCA, is amended to read:

"30-9A-109. Scope. (1) Except as otherwise provided in subsections (3) and (4), this chapter applies to:

(a) any transaction, regardless of its form, that creates a security interest in personal property or fixtures by contract;

(b) an agricultural lien;

(c) a sale of an account, chattel paper, payment intangible, or promissory note;

(d) a consignment;

(e) a security interest arising under 30-2-401, 30-2-505, 30-2-711(3), or 30-2A-508(5), to the extent provided in 30-9A-110; and

(f) a security interest arising under 30-4-208 or 30-5-118.

(2) The application of this chapter to a security interest in a secured obligation is not affected by the fact that the obligation is itself secured by a transaction or interest to which this chapter does not apply.

(3) This chapter does not apply to the extent that:

(a) a statute, regulation, or treaty of the United States preempts this chapter;

(b) another statute of this state expressly governs the creation, perfection, priority, or enforcement of a security interest created by this state or a governmental unit of this state;

(c) a statute of another state, a foreign country, or a governmental unit of another state or a foreign country, other than a statute generally applicable to security interests, expressly governs creation, perfection, priority, or enforcement of a security interest created by the state, country, or governmental unit; or

(d) the rights of a transferee beneficiary or nominated person under a letter of credit are independent and superior under 30-5-134.

(4) This chapter does not apply to:

(a) a landlord's lien, other than an agricultural lien;

(b) a lien, other than an agricultural lien, given by statute or other rule of law for services or materials, but 30-9A-333 applies with respect to priority of the lien;

(c) an assignment of a claim for wages, salary, or other compensation of an employee;

(d) a sale of accounts, chattel paper, payment intangibles, or promissory notes as part of a sale of the

business out of which they arose;

(e) an assignment of accounts, chattel paper, payment intangibles, or promissory notes that is for the purpose of collection only;

(f) an assignment of a right to payment under a contract to an assignee that is also obliged to perform under the contract;

(g) an assignment of a single account, payment intangible, or promissory note to an assignee in full or partial satisfaction of a preexisting indebtedness;

(h) a transfer of an interest in or an assignment of a claim under a policy of insurance, other than an assignment by or to a health care provider of a health-care-insurance receivable and any subsequent assignment of the right to payment, but 30-9A-315 and 30-9A-322 apply with respect to proceeds and priorities in proceeds;

(i) an assignment of a right represented by a judgment, other than a judgment taken on a right to payment that was collateral;

(j) a right of recoupment or setoff, but:

(i) 30-9A-340 applies with respect to the effectiveness of rights of recoupment or setoff against deposit accounts; and

(ii) 30-9A-404 applies with respect to defenses or claims of an account debtor;

(k) the creation or transfer of an interest in or lien on real property, including a lease or rents under the interest in real property, except to the extent that provision is made for:

(i) liens on real property in 30-9A-203 and 30-9A-308;

(ii) fixtures in 30-9A-334;

(iii) fixture filings in 30-9A-501, 30-9A-502, 30-9A-512, 30-9A-516, and 30-9A-519; and

(iv) security agreements covering personal and real property in 30-9A-604;

(l) an assignment of a claim arising in tort, other than a commercial tort claim, but 30-9A-315 and 30-9A-322 apply with respect to proceeds and priorities in proceeds;

(m) a transfer by a government or governmental subdivision or agency;

(n) an assignment of a deposit account in a consumer transaction, except that 30-9A-315 and 30-9A-322 apply with respect to proceeds and priorities in proceeds; or

(o) an assignment of payments made to or on behalf of claimants pursuant to Title 39, chapter 51, 71, ~~72,~~ or 73."

Section 8. Section 37-1-131, MCA, is amended to read:

"37-1-131. Duties of boards -- quorum required. Each board within the department shall:

(1) set and enforce standards and rules governing the licensing, certification, registration, and conduct of the members of the particular profession or occupation within its jurisdiction;

(2) sit in judgment in hearings for the suspension, revocation, or denial of a license of an actual or potential member of the particular profession or occupation within its jurisdiction. The hearings must be conducted by a hearing examiner when required under 37-1-121(1).

(3) suspend, revoke, or deny a license of a person who the board determines, after a hearing as provided in subsection (2), is guilty of knowingly defrauding, abusing, or aiding in the defrauding or abusing of the workers' compensation system in violation of the provisions of Title 39, chapter 71 ~~or 72~~;

(4) pay to the department its pro rata share of the assessed costs of the department under 37-1-101(6);

(5) consult with the department before the board initiates a program expansion, under existing legislation, to determine if the board has adequate money and appropriation authority to fully pay all costs associated with the proposed program expansion. The board may not expand a program if the board does not have adequate money and appropriation authority available.

(6) A board, board panel, or subcommittee convened to conduct board business must have a majority of its members, which constitutes a quorum, present to conduct business."

Section 9. Section 39-71-105, MCA, is amended to read:

"39-71-105. Declaration of public policy. For the purposes of interpreting and applying Title 39, ~~chapters~~ chapter 71 ~~and 72~~, the following is the public policy of this state:

(1) It is an objective of the Montana workers' compensation system to provide, without regard to fault, wage supplement and medical benefits to a worker suffering from a work-related injury or disease. Wage-loss benefits are not intended to make an injured worker whole; they are intended to assist a worker at a reasonable cost to the employer. Within that limitation, the wage-loss benefit should bear a reasonable relationship to actual wages lost as a result of a work-related injury or disease.

(2) A worker's removal from the work force due to a work-related injury or disease has a negative impact on the worker, the worker's family, the employer, and the general public. Therefore, it is an objective of the workers' compensation system to return a worker to work as soon as possible after the worker has suffered a work-related injury or disease.

(3) Montana's workers' compensation and occupational disease insurance systems are intended to be primarily self-administering. Claimants should be able to speedily obtain benefits, and employers should be able

to provide coverage at reasonably constant rates. To meet these objectives, the system must be designed to minimize reliance upon lawyers and the courts to obtain benefits and interpret liabilities.

(4) Title 39, ~~chapters~~ chapter 71 ~~and 72~~, must be construed according to ~~their~~ its terms and not liberally in favor of any party.

(5) It is the intent of the legislature that:

(a) stress claims, often referred to as "mental-mental claims" and "mental-physical claims", are not compensable under Montana's workers' compensation and occupational disease laws. The legislature recognizes that these claims are difficult to objectively verify and that the claims have a potential to place an economic burden on the workers' compensation and occupational disease system. The legislature also recognizes that there are other states that do not provide compensation for various categories of stress claims and that stress claims have presented economic problems for certain other jurisdictions. In addition, not all injuries are compensable under the present system, as is the case with repetitive injury claims, and it is within the legislature's authority to define the limits of the workers' compensation and occupational disease system.

(b) for occupational disease claims, because of the nature of exposure, workers should not be required to provide notice to employers of the disease as required of injuries and that the requirements for filing of claims reflect consideration of when the worker knew or should have known of exposure to an occupational disease. The legislature recognizes that occupational diseases in the workplace are caused by events occurring on more than a single day or work shift and that it is within the legislature's authority to define an occupational disease and establish the causal connection to the workplace."

Section 10. Section 39-71-106, MCA, is amended to read:

"39-71-106. No liability for reporting violation. A person, including but not limited to an insurer or an employer, may not be held liable for civil damages as a result of reporting in good faith information that the person believes proves a violation of the provisions of ~~chapter 72 or~~ this chapter."

Section 11. Section 39-71-107, MCA, is amended to read:

"39-71-107. Insurers to act promptly on claims -- in-state adjusters. (1) Pursuant to the public policy stated in 39-71-105, prompt claims handling practices are necessary to provide appropriate service to injured workers, to employers, and to providers who are the customers of the workers' compensation system.

(2) All workers' compensation and occupational disease claims filed pursuant to the Workers' Compensation Act ~~and the Occupational Disease Act of Montana~~ must be adjusted by a person in Montana. For

a claim to be considered as adjusted by a person in Montana, the person adjusting the claim is required to determine the entitlement to benefits, authorize payment of all benefits due, manage the claim, have authority to settle the claim, maintain an office located in Montana, and adjust Montana claims from that office. Use of a mailbox or maildrop in Montana does not constitute maintaining an office in Montana.

(3) An insurer shall maintain the documents related to each claim filed with the insurer under the Workers' Compensation Act ~~and the Occupational Disease Act of Montana~~ at the Montana office of the person adjusting the claim in Montana until the claim is settled. The documents may be either original documents or duplicates of the original documents and must be maintained in a manner that allows the documents to be retrieved from that office and copied at the request of the claimant or the department. Settled claim files stored outside of the adjuster's office must be made available within 48 hours of a request for the file. Electronic or optically imaged documents are permitted.

(4) An insurer shall provide to the claimant:

(a) a written statement of the reasons that a claim is being denied at the time of denial;

(b) whenever benefits requested by a claimant are denied, a written explanation of how the claimant may appeal an insurer's decision; and

(c) a written explanation of the amount of wage loss benefits being paid to the claimant, along with an explanation of the calculation used to compute those benefits. The explanation must be sent within 7 days of the initial payment of the benefit.

(5) An insurer shall:

(a) begin making payments that are due on a claim within 14 days of acceptance of the claim, unless the insurer promptly notifies the claimant that the insurer needs additional information in order to begin paying benefits and specifies the information needed; and

(b) pay settlements within 30 days of the date the department issues an order approving the settlement.

(6) An insurer may not make payments pursuant to 39-71-608 or any other reservation of rights for more than 90 days without:

(a) written consent of the claimant; or

(b) approval of the department.

(7) The department may adopt rules to implement this section.

(8) (a) For purposes of this section, "settled claim" means a department-approved or court-ordered compromise of benefits between a claimant and an insurer or a claim that was paid in full.

(b) The term does not include a claim in which there has been only a lump-sum advance of benefits."

Section 12. Section 39-71-116, MCA, is amended to read:

"39-71-116. Definitions. Unless the context otherwise requires, in this chapter, the following definitions apply:

(1) "Actual wage loss" means that the wages that a worker earns or is qualified to earn after the worker reaches maximum healing are less than the actual wages the worker received at the time of the injury.

(2) "Administer and pay" includes all actions by the state fund under the Workers' Compensation Act ~~and the Occupational Disease Act of Montana~~ necessary to:

(a) investigation, review, and settlement of claims;

(b) payment of benefits;

(c) setting of reserves;

(d) furnishing of services and facilities; and

(e) use of actuarial, audit, accounting, vocational rehabilitation, and legal services.

(3) "Aid or sustenance" means a public or private subsidy made to provide a means of support, maintenance, or subsistence for the recipient.

(4) "Average weekly wage" means the mean weekly earnings of all employees under covered employment, as defined and established annually by the department. It is established at the nearest whole dollar number and must be adopted by the department before July 1 of each year.

(5) "Beneficiary" means:

(a) a surviving spouse living with or legally entitled to be supported by the deceased at the time of injury;

(b) an unmarried child under 18 years of age;

(c) an unmarried child under 22 years of age who is a full-time student in an accredited school or is enrolled in an accredited apprenticeship program;

(d) an invalid child over 18 years of age who is dependent, as defined in 26 U.S.C. 152, upon the decedent for support at the time of injury;

(e) a parent who is dependent, as defined in 26 U.S.C. 152, upon the decedent for support at the time of the injury if a beneficiary, as defined in subsections (5)(a) through (5)(d), does not exist; and

(f) a brother or sister under 18 years of age if dependent, as defined in 26 U.S.C. 152, upon the decedent for support at the time of the injury but only until the age of 18 years and only when a beneficiary, as defined in subsections (5)(a) through (5)(e), does not exist.

(6) "Business partner" means the community, governmental entity, or business organization that provides the premises for work-based learning activities for students.

(7) "Casual employment" means employment not in the usual course of the trade, business, profession, or occupation of the employer.

(8) "Child" includes a posthumous child, a dependent stepchild, and a child legally adopted prior to the injury.

(9) "Construction industry" means the major group of general contractors and operative builders, heavy construction (other than building construction) contractors, and special trade contractors listed in major group 23 in the North American Industry Classification System Manual. The term does not include office workers, design professionals, salespersons, estimators, or any other related employment that is not directly involved on a regular basis in the provision of physical labor at a construction or renovation site.

(10) "Days" means calendar days, unless otherwise specified.

(11) "Department" means the department of labor and industry.

(12) "Fiscal year" means the period of time between July 1 and the succeeding June 30.

(13) "Household or domestic employment" means employment of persons other than members of the household for the purpose of tending to the aid and comfort of the employer or members of the employer's family, including but not limited to housecleaning and yard work, but does not include employment beyond the scope of normal household or domestic duties, such as home health care or domiciliary care.

(14) "Insurer" means an employer bound by compensation plan No. 1, an insurance company transacting business under compensation plan No. 2, or the state fund under compensation plan No. 3.

(15) "Invalid" means one who is physically or mentally incapacitated.

(16) "Limited liability company" is as defined in 35-8-102.

(17) "Maintenance care" means treatment designed to provide the optimum state of health while minimizing recurrence of the clinical status.

(18) "Medical stability", "maximum healing", or "maximum medical healing" means a point in the healing process when further material improvement would not be reasonably expected from primary medical treatment.

(19) "Objective medical findings" means medical evidence, including range of motion, atrophy, muscle strength, muscle spasm, or other diagnostic evidence, substantiated by clinical findings.

(20) (a) "Occupational disease" means harm, damage, or death arising out of or contracted in the course and scope of employment caused by events occurring on more than a single day or work shift.

(b) The term does not include a physical or mental condition arising from emotional or mental stress or from a nonphysical stimulus or activity.

~~(20)~~(21) "Order" means any decision, rule, direction, requirement, or standard of the department or any

other determination arrived at or decision made by the department.

~~(21)~~(22) "Palliative care" means treatment designed to reduce or ease symptoms without curing the underlying cause of the symptoms.

~~(22)~~(23) "Payroll", "annual payroll", or "annual payroll for the preceding year" means the average annual payroll of the employer for the preceding calendar year or, if the employer has not operated a sufficient or any length of time during the calendar year, 12 times the average monthly payroll for the current year. However, an estimate may be made by the department for any employer starting in business if average payrolls are not available. This estimate must be adjusted by additional payment by the employer or refund by the department, as the case may actually be, on December 31 of the current year. An employer's payroll must be computed by calculating all wages, as defined in 39-71-123, that are paid by an employer.

~~(23)~~(24) "Permanent partial disability" means a physical condition in which a worker, after reaching maximum medical healing:

(a) has a permanent impairment established by objective medical findings;

(b) is able to return to work in some capacity but the permanent impairment impairs the worker's ability to work; and

(c) has an actual wage loss as a result of the injury.

~~(24)~~(25) "Permanent total disability" means a physical condition resulting from injury as defined in this chapter, after a worker reaches maximum medical healing, in which a worker does not have a reasonable prospect of physically performing regular employment. Regular employment means work on a recurring basis performed for remuneration in a trade, business, profession, or other occupation in this state. Lack of immediate job openings is not a factor to be considered in determining if a worker is permanently totally disabled.

~~(25)~~(26) The "plant of the employer" includes the place of business of a third person while the employer has access to or control over the place of business for the purpose of carrying on the employer's usual trade, business, or occupation.

~~(26)~~(27) "Primary medical services" means treatment prescribed by a treating physician, for conditions resulting from the injury, necessary for achieving medical stability.

~~(27)~~(28) "Public corporation" means the state or a county, municipal corporation, school district, city, city under a commission form of government or special charter, town, or village.

~~(28)~~(29) "Reasonably safe place to work" means that the place of employment has been made as free from danger to the life or safety of the employee as the nature of the employment will reasonably permit.

~~(29)~~(30) "Reasonably safe tools and appliances" are tools and appliances that are adapted to and that

are reasonably safe for use for the particular purpose for which they are furnished.

~~(30)~~(31) (a) "Secondary medical services" means those medical services or appliances that are considered not medically necessary for medical stability. The services and appliances include but are not limited to spas or hot tubs, work hardening, physical restoration programs and other restoration programs designed to address disability and not impairment, or equipment offered by individuals, clinics, groups, hospitals, or rehabilitation facilities.

(b) (i) As used in this subsection ~~(30)~~ (31), "disability" means a condition in which a worker's ability to engage in gainful employment is diminished as a result of physical restrictions resulting from an injury. The restrictions may be combined with factors, such as the worker's age, education, work history, and other factors that affect the worker's ability to engage in gainful employment.

(ii) Disability does not mean a purely medical condition.

~~(31)~~(32) "Sole proprietor" means the person who has the exclusive legal right or title to or ownership of a business enterprise.

~~(32)~~(33) "Temporary partial disability" means a physical condition resulting from an injury, as defined in 39-71-119, in which a worker, prior to maximum healing:

(a) is temporarily unable to return to the position held at the time of injury because of a medically determined physical restriction;

(b) returns to work in a modified or alternative employment; and

(c) suffers a partial wage loss.

~~(33)~~(34) "Temporary service contractor" means a person, firm, association, partnership, limited liability company, or corporation conducting business that hires its own employees and assigns them to clients to fill a work assignment with a finite ending date to support or supplement the client's workforce in situations resulting from employee absences, skill shortages, seasonal workloads, and special assignments and projects.

~~(34)~~(35) "Temporary total disability" means a physical condition resulting from an injury, as defined in this chapter, that results in total loss of wages and exists until the injured worker reaches maximum medical healing.

~~(35)~~(36) "Temporary worker" means a worker whose services are furnished to another on a part-time or temporary basis to fill a work assignment with a finite ending date to support or supplement a workforce in situations resulting from employee absences, skill shortages, seasonal workloads, and special assignments and projects.

~~(36)~~(37) "Treating physician" means a person who is primarily responsible for the treatment of a worker's compensable injury and is:

(a) a physician licensed by the state of Montana under Title 37, chapter 3, and has admitting privileges to practice in one or more hospitals, if any, in the area where the physician is located;

(b) a chiropractor licensed by the state of Montana under Title 37, chapter 12;

(c) a physician assistant-certified licensed by the state of Montana under Title 37, chapter 20, if there is not a treating physician, as provided for in subsection ~~(36)(a)~~ (37)(a), in the area where the physician assistant-certified is located;

(d) an osteopath licensed by the state of Montana under Title 37, chapter 3;

(e) a dentist licensed by the state of Montana under Title 37, chapter 4;

(f) for a claimant residing out of state or upon approval of the insurer, a treating physician defined in subsections ~~(36)(a)~~ (37)(a) through ~~(36)(e)~~ (37)(e) who is licensed or certified in another state; or

(g) an advanced practice registered nurse licensed by the state of Montana under Title 37, chapter 8, recognized by the board of nursing as a nurse practitioner or a clinical nurse specialist, and practicing in consultation with a physician licensed under Title 37, chapter 3, if there is not a treating physician, as provided for in subsection ~~(36)(a)~~ (37)(a), in the area in which the advanced practice registered nurse is located.

~~(37)~~(38) "Work-based learning activities" means job training and work experience conducted on the premises of a business partner as a component of school-based learning activities authorized by an elementary, secondary, or postsecondary educational institution.

~~(38)~~(39) "Year", unless otherwise specified, means calendar year."

Section 13. Section 39-71-201, MCA, is amended to read:

"39-71-201. Administration fund. (1) A workers' compensation administration fund is established out of which all costs of administering the Workers' Compensation ~~and Occupational Disease Acts~~ Act and the statutory occupational safety acts that the department is required to administer, with the exception of the subsequent injury fund, as provided for in 39-71-907, and the uninsured employers' fund, are to be paid upon lawful appropriation. The department shall collect and deposit in the state treasury to the credit of the workers' compensation administration fund:

(a) all fees and penalties provided in 39-71-205, 39-71-223, 39-71-304, 39-71-307, 39-71-308, 39-71-315, 39-71-316, 39-71-401(6), 39-71-2204, 39-71-2205, and 39-71-2337; and

(b) all fees paid by an assessment of 3% of paid losses, plus administrative fines and interest provided by this section.

(2) For the purposes of this section, paid losses include the following benefits paid during the preceding

calendar year for injuries covered by the Workers' Compensation Act ~~and the Occupational Disease Act of Montana~~ without regard to the application of any deductible whether the employer or the insurer pays the losses:

(a) total compensation benefits paid; and

(b) except for medical benefits in excess of $200,000 for each occurrence that are exempt from assessment, total medical benefits paid for medical treatment rendered to an injured worker, including hospital treatment and prescription drugs.

(3) Each plan No. 1 employer, plan No. 2 insurer subject to the provisions of this section, and plan No. 3, the state fund, shall file annually on March 1 in the form and containing the information required by the department a report of paid losses pursuant to subsection (2).

(4) Each employer enrolled under compensation plan No. 1, compensation plan No. 2, or compensation plan No. 3, the state fund, shall pay a proportionate share of all costs of administering and regulating the Workers' Compensation Act ~~and the Occupational Disease Act of Montana~~ and the statutory occupational safety acts that the department is required to administer, with the exception of the subsequent injury fund, as provided for in 39-71-907, and the uninsured employers' fund. In addition, compensation plan No. 3, the state fund, shall pay a proportionate share of these costs based upon paid losses for claims arising before July 1, 1990.

(5) (a) Each employer enrolled under compensation plan No. 1 shall pay an assessment to fund administrative and regulatory costs. The assessment is equal to 3% of the paid losses paid in the preceding calendar year by or on behalf of the plan No. 1 employer or $500, whichever is greater. Any entity, other than the department, that assumes the obligations of an employer enrolled under compensation plan No. 1 is considered to be the employer for the purposes of this section.

(b) An employer formerly enrolled under compensation plan No. 1 shall pay an assessment to fund administrative and regulatory costs. The assessment is equal to 3% of the paid losses paid in the preceding calendar year by or on behalf of the employer for claims arising out of the time when the employer was enrolled under compensation plan No. 1.

(c) Payment of the assessment provided for by this subsection (5) must be paid by the employer in:

(i) one installment due on July 1; or

(ii) two equal installments due on July 1 and December 31 of each year.

(d) If an employer fails to timely pay to the department the assessment under this section, the department may impose on the employer an administrative fine of $500 plus interest on the delinquent amount at the annual interest rate of 12%. Administrative fines and interest must be deposited in the workers' compensation administration fund.

(6) (a) Compensation plan No. 3, the state fund, shall pay an assessment to fund administrative and regulatory costs attributable to claims arising before July 1, 1990. The assessment is equal to 3% of the paid losses paid in the preceding calendar year for claims arising before July 1, 1990. As required by 39-71-2352, the state fund may not pass along to insured employers the cost of the assessment for administrative and regulatory costs that is attributable to claims arising before July 1, 1990.

(b) Payment of the assessment must be paid in:

(i) one installment due on July 1; or

(ii) two equal installments due on July 1 and December 31 of each year.

(c) If the state fund fails to timely pay to the department the assessment under this section, the department may impose on the state fund an administrative fine of $500 plus interest on the delinquent amount at the annual interest rate of 12%. Administrative fines and interest must be deposited in the workers' compensation administration fund.

(7) (a) Each employer insured under compensation plan No. 2 or plan No. 3, the state fund, shall pay a premium surcharge to fund administrative and regulatory costs. The premium surcharge must be collected by each plan No. 2 insurer and by plan No. 3, the state fund, from each employer that it insures. The premium surcharge must be stated as a separate cost on an insured employer's policy or on a separate document submitted to the insured employer and must be identified as "workers' compensation regulatory assessment surcharge". The premium surcharge must be excluded from the definition of premiums for all purposes, including computation of insurance producers' commissions or premium taxes. However, an insurer may cancel a workers' compensation policy for nonpayment of the premium surcharge. When collected, assessments may not constitute an element of loss for the purpose of establishing rates for workers' compensation insurance but, for the purpose of collection, must be treated as a separate cost imposed upon insured employers.

(b) The amount to be funded by the premium surcharge is equal to 3% of the paid losses paid in the preceding calendar year by or on behalf of all plan No. 2 insurers and 3% of paid losses for claims arising on or after July 1, 1990, for plan No. 3, the state fund, plus or minus any adjustments as provided by subsection (7)(f). The amount to be funded must be divided by the total premium paid by all employers enrolled under compensation plan No. 2 or plan No. 3 during the preceding calendar year. A single premium surcharge rate, applicable to all employers enrolled in compensation plan No. 2 or plan No. 3, must be calculated annually by the department by not later than April 30. The resulting rate, expressed as a percentage, is levied against the premium paid by each employer enrolled under compensation plan No. 2 or plan No. 3 in the next fiscal year.

(c) On or before April 30, 2001, and on each succeeding April 30, the department, in consultation with

the advisory organization designated pursuant to 33-16-1023, shall notify plan No. 2 insurers and plan No. 3, the state fund, of the premium surcharge percentage to be effective for policies written or renewed annually on and after July 1 of that year.

(d) The premium surcharge must be paid whenever the employer pays a premium to the insurer. Each insurer shall collect the premium surcharge levied against every employer that it insures. Each insurer shall pay to the department all money collected as a premium surcharge within 20 days of the end of the calendar quarter in which the money was collected. If an insurer fails to timely pay to the department the premium surcharge collected under this section, the department may impose on the insurer an administrative fine of $500 plus interest on the delinquent amount at the annual interest rate of 12%. Administrative fines and interest must be deposited in the workers' compensation administration fund.

(e) If an employer fails to remit to an insurer the total amount due for the premium and premium surcharge, the amount received by the insurer must be applied to the premium surcharge first and the remaining amount applied to the premium due.

(f) The amount actually collected as a premium surcharge in a given year must be compared to the 3% of paid losses paid in the preceding year. Any amount collected in excess of the 3% must be deducted from the amount to be collected as a premium surcharge in the following year. The amount collected that is less than the 3% must be added to the amount to be collected as a premium surcharge in the following year.

(8) On or before April 30~~, 2001, and on~~ of each ~~succeeding April 30~~ year, upon a determination by the department, an insurer under compensation plan No. 2 that pays benefits in the preceding calendar year but that will not collect any premium for coverage in the following fiscal year shall pay an assessment equal to 3% of paid losses paid in the preceding calendar year, subject to a minimum assessment of $500, that is due on July 1.

(9) An employer that makes a first-time application for permission to enroll under compensation plan No. 1 shall pay an assessment of $500 within 15 days of being granted permission by the department to enroll under compensation plan No. 1.

(10) The department shall deposit all funds received pursuant to this section in the state treasury, as provided in this section.

(11) The administration fund must be debited with expenses incurred by the department in the general administration of the provisions of this chapter, including the salaries of its members, officers, and employees and the travel expenses of the members, officers, and employees, as provided for in 2-18-501 through 2-18-503, incurred while on the business of the department either within or without the state.

(12) Disbursements from the administration money must be made after being approved by the

department upon claim for disbursement.

(13) The department may assess and collect the workers' compensation regulatory assessment surcharge from uninsured employers, as defined in 39-71-501, that fail to properly comply with the coverage requirements of the Workers' Compensation Act ~~and the Occupational Disease Act of Montana~~. Any amounts collected by the department pursuant to this subsection must be deposited in the workers' compensation administration fund."

Section 14. Section 39-71-206, MCA, is amended to read:

"39-71-206. Legal advisers of department and state fund -- investigative and prosecution services. (1) The attorney general is the legal adviser of the department and the state fund and shall represent either entity in all proceedings if requested by the department or state fund. The department and state fund may employ other attorneys or legal advisers as they consider necessary.

(2) As provided in 2-15-2015, the attorney general shall provide investigative and prosecution services to the state fund with respect to violations of ~~Title 39, chapters~~ this chapter ~~71 and 72~~."

Section 15. Section 39-71-211, MCA, is amended to read:

"39-71-211. Fraud detection and prevention unit -- expenditure accounting. (1) The state fund shall establish a fraud prevention and detection unit. The unit is responsible for developing detection and prevention procedures, providing detection services, and providing training in the prevention and detection of fraudulent conduct under Title 39, ~~chapters~~ chapter 71 ~~and 72~~, that is subject to prosecution under Title 45. The unit shall refer all cases of suspected fraudulent conduct to the workers' compensation fraud investigation and prosecution office established in 2-15-2015.

(2) The state fund shall expend money to investigate fraud pursuant to this section and shall separately account for money expended."

Section 16. Section 39-71-315, MCA, is amended to read:

"39-71-315. Prohibited actions -- penalty. (1) The following actions by a medical provider constitute violations and are subject to the penalty in subsection (2):

(a) failing to document, under oath, the provision of the services or treatment for which compensation is claimed under ~~chapter 72 or~~ this chapter; or

(b) referring a worker for treatment or diagnosis of an injury or illness that is compensable under ~~chapter~~

~~72 or~~ this chapter to a facility owned wholly or in part by the provider, unless the provider informs the worker of the ownership interest and provides the name and address of alternate facilities, if any exist.

(2) A person who violates this section may be assessed a penalty of not less than $200 or more than $500 for each offense. The department shall assess and collect the penalty. Penalties collected pursuant to this section must be paid into the state general fund. The workers' compensation court has jurisdiction over actions brought to collect the penalty and over disputes concerning the penalty assessment. Disputes brought pursuant to this section are not subject to mediation.

(3) Subsection (1)(b) does not apply to medical services provided to an injured worker by a treating physician with an ownership interest in a managed care organization that has been certified by the department."

Section 17. Section 39-71-316, MCA, is amended to read:

"39-71-316. Filing true claim -- obtaining benefits through deception or other fraudulent means. (1) A person filing a claim under ~~chapter 72 or~~ this chapter, by signing the claim, affirms the information filed is true and correct to the best of that person's knowledge.

(2) (a) A person who obtains or assists in obtaining benefits to which the person is not entitled or who obtains or assists another person in obtaining benefits to which the other person is not entitled under ~~chapter 72 or~~ this chapter is guilty of theft and may be prosecuted under 45-6-301. A county attorney or the attorney general may initiate criminal proceedings against the person. This subsection includes but is not limited to a person who is receiving temporary total disability benefits, permanent total disability benefits, or rehabilitation benefits while working without the knowledge and concurrence of the insurer.

(b) As used in subsection (2)(a), "person" includes but is not limited to an employee, employer, insurer, or medical service provider.

(3) (a) The department may require a person convicted of theft under 45-6-301(5) to pay to the department an amount equal to 10 times the amount paid by an insurer on the false claim, provided that the amount does not exceed $50,000. If upon demand of the department the person refuses to pay the fine, the department may petition the workers' compensation court to collect the money owed.

(b) The department shall:

(i) use the money collected pursuant to subsection (3)(a) to administer and enforce the provisions of this section; and

(ii) forward any surplus money to the department of justice. The forwarded money must be used exclusively for the staffing and operation of the workers' compensation fraud investigation and prosecution office

established in 2-15-2015.

(c) This section does not limit an insurer's civil remedies to collect for money paid to a person convicted under 45-6-301(5).

(4) A person licensed under the provisions of Title 37 is subject to suspension, revocation, or denial of a license if the person knowingly claims or assists in the claiming of benefits in violation of the provisions of ~~chapter 72 or~~ this chapter."

Section 18. Section 39-71-317, MCA, is amended to read:

"39-71-317. Employer not to terminate worker for filing claim -- preference -- jurisdiction over dispute. (1) An employer may not use as grounds for terminating a worker the filing of a claim under ~~chapter 72 or~~ this chapter. The district court has exclusive jurisdiction over disputes concerning the grounds for termination under this section.

(2) When an injured worker is capable of returning to work within 2 years from the date of injury and has received a medical release to return to work, the worker must be given a preference over other applicants for a comparable position that becomes vacant if the position is consistent with the worker's physical condition and vocational abilities.

(3) This preference applies only to employment with the employer for whom the employee was working at the time the injury occurred.

(4) The workers' compensation court has exclusive jurisdiction to administer or resolve a dispute concerning the reemployment preference under this section. A dispute concerning the reemployment preference is not subject to mediation or a contested case hearing."

Section 19. Section 39-71-403, MCA, is amended to read:

"39-71-403. Plan three exclusive for state agencies -- election of plan by public corporations -- financing of self-insurance fund -- exemption for university system -- definition. (1) Except as provided in subsection (5), if a state agency is the employer, the terms, conditions, and provisions of compensation plan No. 3, state fund, are exclusive, compulsory, and obligatory upon both employer and employee. Any sums necessary to be paid under the provisions of this chapter by a state agency are considered to be ordinary and necessary expenses of the agency. The agency shall ~~make appropriation of and~~ pay the sums into the state fund at the time and in the manner provided for in this chapter, notwithstanding that the state agency may have failed to anticipate the ordinary and necessary expense in a budget, estimate of expenses, appropriations, ordinances, or otherwise.

(2) A public corporation, other than a state agency, may elect coverage under compensation plan No. 1, plan No. 2, or plan No. 3, separately or jointly with any other public corporation, other than a state agency. A public corporation electing compensation plan No. 1 may purchase reinsurance or issue bonds or notes pursuant to subsection (3)(b). A public corporation electing compensation plan No. 1 is subject to the same provisions as a private employer electing compensation plan No. 1.

(3) (a) A public corporation, other than a state agency, that elects plan No. 1 may establish a fund sufficient to pay the compensation and benefits provided for in ~~chapter 72 and~~ this chapter and to discharge all liabilities that are reasonably incurred during the fiscal year for which the election is effective. Proceeds from the fund must be used only to pay claims covered by ~~chapter 72 and~~ this chapter and for actual and necessary expenses required for the efficient administration of the fund, including debt service on any bonds and notes issued pursuant to subsection (3)(b).

(b) (i) A public corporation, other than a state agency, separately or jointly with another public corporation, other than a state agency, may issue and sell its bonds and notes for the purpose of establishing, in whole or in part, the self-insurance workers' compensation fund provided for in subsection (3)(a) and to pay the costs associated with the sale and issuance of the bonds. Bonds and notes may be issued in an amount not exceeding 0.18% of the total assessed value of taxable property, determined as provided in 15-8-111, of the public corporation as of the date of issue. The bonds and notes must be authorized by resolution of the governing body of the public corporation and are payable from an annual property tax levied in the amount necessary to pay principal and interest on the bonds or notes. This authority to levy an annual property tax exists despite any provision of law or maximum levy limitation, including 15-10-420, to the contrary. The revenue derived from the sale of the bonds and notes may not be used for any other purpose.

(ii) The bonds and notes:

(A) may be sold at public or private sale;

(B) do not constitute debt within the meaning of any statutory debt limitation; and

(C) may contain other terms and provisions that the governing body determines.

(iii) Two or more public corporations, other than state agencies, may agree to exercise their respective borrowing powers jointly under this subsection (3)(b) or may authorize a joint board to exercise the powers on their behalf.

(iv) The fund established from the proceeds of bonds and notes issued and sold under this subsection (3)(b) may, if sufficient, be used in lieu of a surety bond, reinsurance, specific and aggregate excess insurance, or any other form of additional security necessary to demonstrate the public corporation's ability to discharge all

liabilities as provided in subsection (3)(a). Subject to the total assessed value limitation in subsection (3)(b)(i), a public corporation may issue bonds and notes to establish a fund sufficient to discharge liabilities for periods greater than 1 year.

(4) All money in the fund established under subsection (3)(a) not needed to meet immediate expenditures must be invested by the governing body of the public corporation or the joint board created by two or more public corporations as provided in subsection (3)(b)(iii), and all proceeds of the investment must be credited to the fund.

(5) The provisions of subsection (1) do not apply to the Montana university system.

(6) As used in subsections (2) through (4), "public corporation" includes the Montana university system."

Section 20. Section 39-71-407, MCA, is amended to read:

"39-71-407. Liability of insurers -- limitations. (1) ~~Each~~ For workers' compensation injuries, each insurer is liable for the payment of compensation, in the manner and to the extent provided in this section, to an employee of an employer covered under plan No. 1, plan No. 2, and the state fund under plan No. 3 that it insures who receives an injury arising out of and in the course of employment or, in the case of death from the injury, to the employee's beneficiaries, if any.

(2) (a) An insurer is liable for an injury, as defined in 39-71-119, if the injury is established by objective medical findings and if the claimant establishes that it is more probable than not that:

(i) a claimed injury has occurred; or

(ii) a claimed injury aggravated a preexisting condition.

(b) Proof that it was medically possible that a claimed injury occurred or that the claimed injury aggravated a preexisting condition is not sufficient to establish liability.

(3) (a) An employee who suffers an injury or dies while traveling is not covered by this chapter unless:

(i) the employer furnishes the transportation or the employee receives reimbursement from the employer for costs of travel, gas, oil, or lodging as a part of the employee's benefits or employment agreement and the travel is necessitated by and on behalf of the employer as an integral part or condition of the employment; or

(ii) the travel is required by the employer as part of the employee's job duties.

(b) A payment made to an employee under a collective bargaining agreement, personnel policy manual, or employee handbook or any other document provided to the employee that is not wages but is designated as an incentive to work at a particular jobsite is not a reimbursement for the costs of travel, gas, oil, or lodging, and the employee is not covered under this chapter while traveling.

(4) An employee is not eligible for benefits otherwise payable under this chapter if the employee's use of alcohol or drugs not prescribed by a physician is the major contributing cause of the accident. However, if the employer had knowledge of and failed to attempt to stop the employee's use of alcohol or drugs, this subsection does not apply.

(5) If a claimant who has reached maximum healing suffers a subsequent nonwork-related injury to the same part of the body, the workers' compensation insurer is not liable for any compensation or medical benefits caused by the subsequent nonwork-related injury.

(6) An employee is not eligible for benefits payable under this chapter unless the entitlement to benefits is established by objective medical findings that contain sufficient factual and historical information concerning the relationship of the worker's condition to the original injury.

(7) For occupational diseases, every employer enrolled under plan No. 1, every insurer under plan No. 2, or the state fund under plan No. 3 is liable for the payment of compensation, in the manner and to the extent provided in this chapter, to an employee of an employer covered under plan No. 1, plan No. 2, or the state fund under plan No. 3 with an occupational disease that arises out of or is contracted in the course and scope of employment.

(8) Occupational diseases are considered to arise out of employment or be contracted in the course and scope of employment if:

(a) the occupational disease is established by objective medical findings; and

(b) the events occurring on more than a single day or work shift are more than 50% responsible for the occupational disease in relation to other factors contributing to the occupational disease.

(9) When compensation is payable for an occupational disease, the only employer liable is the employer in whose employment the employee was last injuriously exposed to the hazard of the disease.

(10) When there is more than one insurer and only one employer at the time that the employee was injuriously exposed to the hazard of the disease, the liability rests with the insurer providing coverage at the earlier of:

(a) the time that the occupational disease was first diagnosed by a treating physician or medical panel; or

(b) the time that the employee knew or should have known that the condition was the result of an occupational disease.

(11) In the case of pneumoconiosis, any coal mine operator who has acquired a mine in the state or substantially all of the assets of a mine from a person who was an operator of the mine on or after December 30,

1969, is liable for and shall secure the payment of all benefits that would have been payable by that person with respect to miners previously employed in the mine if acquisition had not occurred and that person had continued to operate the mine, and the prior operator of the mine is not relieved of any liability under this section.

~~(7)~~(12) As used in this section, "major contributing cause" means a cause that is the leading cause contributing to the result when compared to all other contributing causes."

Section 21. Section 39-71-416, MCA, is amended to read:

"39-71-416. Benefit reduction for third-party recovery. (1) If an employee is injured or dies and obtains a third-party recovery, settlement, or award, an insurer may reduce by 30% the benefits paid or that are required to be paid to the employee or beneficiary pursuant to this chapter ~~71 or 72~~ as a result of the injury or death. The reduction applies to any recovery, settlement, or award regardless of the form of action or the nature of damages. The total of any reductions may not exceed 30% of any third-party recovery, settlement, or award.

(2) This section does not limit or prohibit an insurer's right to pursue subrogation pursuant to 39-71-414.

(3) If an insurer is entitled to subrogation pursuant to 39-71-414, the amount subrogated must be offset by any reduction in benefits pursuant to subsection (1)."

Section 22. Section 39-71-525, MCA, is amended to read:

"39-71-525. Confidentiality of records -- exception for use by public employees. Information obtained from any individual under this part is confidential and may not be disclosed, sold, or opened to public inspection except to department employees when necessary to allow them to perform their public duties under Title 39, ~~chapters~~ chapter 71 ~~and 72~~, or to provide relevant and necessary information to other public entities or pursuant to a subpoena issued upon a showing of compelling state interest."

Section 23. Section 39-71-601, MCA, is amended to read:

"39-71-601. Statute of limitation on presentment of claim -- waiver. (1) ~~In case of personal injury or death~~ Except for a claim for benefits for occupational diseases pursuant to subsections (3) and (4), all claims in the case of personal injury or death must be forever barred unless signed by the claimant or the claimant's representative and presented in writing to the employer, the insurer, or the department, as the case may be, within 12 months from the date of the happening of the accident, either by the claimant or someone legally authorized to act on the claimant's behalf.

(2) The insurer may waive the time requirement up to an additional 24 months upon a reasonable

showing by the claimant of:

(a) lack of knowledge of disability;

(b) latent injury; or

(c) equitable estoppel.

(3) When a claimant seeks benefits for an occupational disease, the claimant's claims for benefits must be presented in writing to the employer, the employer's insurer, or the department within 1 year from the date that the claimant knew or should have known that the claimant's condition resulted from an occupational disease. When a beneficiary seeks benefits under this chapter, claims for death benefits must be presented in writing to the employer, the employer's insurer, or the department within 1 year from the date that the beneficiary knew or should have known that the decedent's death was related to an occupational disease.

~~(3)~~(4) Any dispute regarding the statute of limitations for filing time is considered a dispute that, after mediation pursuant to department rules, is subject to jurisdiction of the workers' compensation court."

Section 24. Section 39-71-603, MCA, is amended to read:

"39-71-603. Notice of injuries other than death to be submitted within thirty days -- exception. (1) A claim to recover benefits under the Workers' Compensation Act for injuries not resulting in death may not be considered compensable unless, within 30 days after the occurrence of the accident that is claimed to have caused the injury, notice of the time and place where the accident occurred and the nature of the injury is given to the employer or the employer's insurer by the injured employee or someone on the employee's behalf. Actual knowledge of the accident and injury on the part of the employer or the employer's managing agent or superintendent in charge of the work in which the injured employee was engaged at the time of the injury is equivalent to notice.

(2) If a sole proprietor, partner, manager of a manager-managed limited liability company, member of a member-managed limited liability company, or corporate officer covered under this chapter is injured in an accident, the sole proprietor, partner, manager, member, or corporate officer or an appointed designee shall, within 30 days, notify the insurer of the time and location of the accident and the nature of the injury.

(3) This section does not apply to occupational diseases."

Section 25. Section 39-71-612, MCA, is amended to read:

"39-71-612. Costs and attorney fees that may be assessed against insurer by workers' compensation judge -- barring of attorney fees under common fund or other doctrines. (1) If an insurer

pays or submits a written offer of payment of compensation under this chapter ~~71 or 72 of this title~~ but controversy relates to the amount of compensation due, the case is brought before the workers' compensation judge for adjudication of the controversy, and the award granted by the judge is greater than the amount paid or offered by the insurer, reasonable attorney fees and costs as established by the workers' compensation judge if the case has gone to a hearing may be awarded by the judge in addition to the amount of compensation.

(2) An award of attorney fees under subsection (1) may be made only if it is determined that the actions of the insurer were unreasonable. Any written offer of payment made 30 days or more before the date of hearing must be considered a valid offer of payment for the purposes of this section.

(3) A finding of unreasonableness against an insurer made under this section does not constitute a finding that the insurer acted in bad faith or violated the unfair trade practices provisions of Title 33, chapter 18.

(4) Attorney fees may be awarded only under the provisions of subsections (1) and (2) and may not be awarded under the common fund doctrine or any other action or doctrine in law or equity."

Section 26. Section 39-71-743, MCA, is amended to read:

"39-71-743. Assignment or attachment of payments. (1) Payments under this chapter may not be assignable, subject to attachment or garnishment, or held liable in any way for debts, except:

(a) as provided in 71-3-1118;

(b) a portion of any lump-sum award or periodic payment to pay a monetary obligation for current or past-due child support, subject to the limitations in subsection (2), whenever the support obligation is established by order of a court of competent jurisdiction or by order rendered in an administrative process authorized by state law; or

(c) as provided in 53-2-612 or 53-2-613 for medical benefits paid pursuant to ~~chapter 71 or 72 of~~ this ~~title~~ chapter.

(2) Payments under this chapter are subject to assignment, attachment, or garnishment for child support as follows:

(a) for any periodic payment, an amount up to the percentage amount established in the guidelines promulgated by the department of public health and human services pursuant to 40-5-209; or

(b) for any lump-sum award, an amount up to that portion of the award that is approved for payment on the basis of a past-due child support obligation.

(3) After determination that the claim is covered under the Workers' Compensation Act ~~or Occupational Disease Act of Montana~~, the liability for payment of the claim is the responsibility of the appropriate workers'

compensation insurer. Except as provided in 39-71-704(7), a fee or charge is not payable by the injured worker for treatment of injuries sustained if liability is accepted by the insurer."

Section 27. Section 39-71-915, MCA, is amended to read:

"39-71-915. Assessment of insurer -- employers -- definition -- collection. (1) As used in this section, "paid losses" means the following benefits paid during the preceding calendar year for injuries covered by the ~~Montana~~ Workers' Compensation Act ~~and the Occupational Disease Act of Montana~~ without regard to the application of any deductible, regardless of whether the employer or the insurer pays the losses:

(a) total compensation benefits paid; and

(b) except for medical benefits in excess of $200,000 for each occurrence that are exempt from assessment, total medical benefits paid for medical treatment rendered to an injured worker, including hospital treatment and prescription drugs.

(2) The fund must be maintained by assessing each plan No. 1 employer, each employer insured by a plan No. 2 insurer, plan No. 3, the state fund, with respect to claims arising before July 1, 1990, and each employer insured by plan No. 3, the state fund. The assessment amount is the total amount of paid losses reimbursed from the fund in the preceding calendar year and the expenses of administration less other income. The total assessment amount to be collected must be allocated among plan No. 1 employers, plan No. 2 employers, plan No. 3, the state fund, and plan No. 3 employers, based on a proportionate share of paid losses for the calendar year preceding the year in which the assessment is collected. The board of investments shall invest the money of the fund, and the investment income must be deposited in the fund.

(3) On or before May 31 each year, the department shall notify each plan No. 1 employer, plan No. 2 insurer, and plan No. 3, the state fund, of the amount to be assessed for the ensuing fiscal year. The amount to be assessed against the state fund must separately identify the amount attributed to claims arising before July 1, 1990, and the amount attributable to state fund claims arising on or after July 1, 1990. On or before April 30 each year, the department, in consultation with the advisory organization designated under 33-16-1023, shall notify plan No. 2 insurers and plan No. 3 of the premium surcharge rate to be effective for policies written or renewed on and after July 1 in that year.

(4) The portion of the plan No. 1 assessment assessed against an individual plan No. 1 employer is a proportionate amount of total plan No. 1 paid losses during the preceding calendar year that is equal to the percentage that the total paid losses of the individual plan No. 1 employer bore to the total paid losses of all plan No. 1 employers during the preceding calendar year.

(5) The portion of the assessment attributable to state fund claims arising before July 1, 1990, is the proportionate amount that is equal to the percentage that total paid losses for those claims during the preceding calendar year bore to the total paid losses for all plans in the preceding calendar year. As required by 39-71-2352, the state fund may not pass along to insured employers the cost of the subsequent injury fund assessment that is attributable to claims arising before July 1, 1990.

(6) The remaining portion of the assessment must be paid by way of a surcharge on premiums paid by employers being insured by a plan No. 2 insurer or plan No. 3, the state fund, for policies written or renewed annually on or after July 1. The surcharge rate must be computed by dividing the remaining portion of the assessment by the total amount of premiums paid by employers insured under plan No. 2 or plan No. 3 in the previous calendar year. The numerator for the calculation must be adjusted as provided by subsection (9).

(7) Each plan No. 2 insurer providing workers' compensation insurance and plan No. 3, the state fund, shall collect from its policyholders the assessment premium surcharge provided for in subsection (6). When collected, the assessment premium surcharge may not constitute an element of loss for the purpose of establishing rates for workers' compensation insurance but, for the purpose of collection, must be treated as separate costs imposed upon insured employers. The total of this assessment premium surcharge must be stated as a separate cost on an insured employer's policy or on a separate document submitted by the insured employer and must be identified as "workers' compensation subsequent injury fund surcharge". Each assessment premium surcharge must be shown as a percentage of the total workers' compensation policyholder premium. This assessment premium surcharge must be collected at the same time and in the same manner that the premium for the coverage is collected. The assessment premium surcharge must be excluded from the definition of premiums for all purposes, including computation of insurance producers' commissions or premium taxes, except that an insurer may cancel a workers' compensation policy for nonpayment of the assessment premium surcharge. Cancellation must be in accordance with the procedures applicable to the nonpayment of premium. If an employer fails to remit to an insurer the total amount due for the premium and assessment premium surcharge, the amount received by the insurer must be applied to the assessment premium surcharge first and the remaining amount applied to the premium due.

(8) (a) All assessments paid to the department must be deposited in the fund.

(b) Each plan No. 1 employer shall pay its assessment by July 1.

(c) Each plan No. 2 insurer and plan No. 3, the state fund, shall remit to the department all assessment premium surcharges collected during a calendar quarter by not later than 20 days following the end of the quarter.

(d) The state fund shall pay the portion of the assessment attributable to claims arising before July 1,

1990, by July 1.

(e) If a plan No. 1 employer, a plan No. 2 insurer, or plan No. 3, the state fund, fails to timely pay to the department the assessment or assessment premium surcharge under this section, the department may impose on the plan No. 1 employer, the plan No. 2 insurer, or plan No. 3, the state fund, an administrative fine of $100 plus interest on the delinquent amount at the annual interest rate of 12%. Administrative fines and interest must be deposited in the fund.

(9) The amount of the assessment premium surcharge actually collected pursuant to subsection (7) must be compared each year to the amount assessed and upon which the premium surcharge was calculated. The amount undercollected or overcollected in any given year must be used as an adjustment to the numerator provided for by subsection (6) for the following year's assessment premium surcharge."

Section 28. Section 39-71-1105, MCA, is amended to read:

"39-71-1105. Managed care organizations -- application -- certification. (1) A health care provider, a group of medical service providers, or an entity with a managed care organization may make written application to the department to become certified under this section to provide managed care to ~~injured~~ workers for injuries or occupational diseases that are covered under this chapter ~~or for occupational diseases that are covered under the Occupational Disease Act of Montana~~. However, this section does not authorize an organization that is formed, owned, or operated by a workers' compensation insurer or self-insured employer other than a health care provider to become certified to provide managed care. When a health care provider, a group of medical service providers, or an entity with a managed care organization is establishing a managed care organization and independent physical therapy practices exist in the community, the managed care organization is encouraged to utilize independent physical therapists as part of the managed care organization if the independent physical therapists agree to abide by all the applicable requirements for a managed care organization set forth in this section, in rules established by the department, and in the provisions of a managed care plan for which certification is being sought.

(2) Each application for certification must be accompanied by an application fee if prescribed by the department. A certificate is valid for the period prescribed by the department, unless it is revoked or suspended at an earlier date.

(3) The department shall establish by rule the form for the application for certification and the required information regarding the proposed plan for providing medical services. The information includes but is not limited to:

(a) a list of names of each individual who will provide services under the managed care plan, together with appropriate evidence of compliance with any licensing or certification requirements for that individual to practice in the state;

(b) names of the individuals who will be designated as treating physicians and who will be responsible for the coordination of medical services;

(c) a description of the times, places, and manner of providing primary medical services under the plan;

(d) a description of the times, places, and manner of providing secondary medical services, if any, that the applicants wish to provide; and

(e) satisfactory evidence of the ability to comply with any financial requirements to ensure delivery of service in accordance with the plan that the department may require.

(4) The department shall certify a group of medical service providers or an entity with a managed care organization to provide managed care under a plan if the department finds that the plan:

(a) proposes to provide coordination of services that meet quality, continuity, and other treatment standards prescribed by the department and will provide all primary medical services that may be required by this chapter in a manner that is timely and effective for the worker;

(b) provides appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of services;

(c) provides adequate methods of peer review and service utilization review to prevent excessive or inappropriate treatment, to exclude from participation in the plan those individuals who violate these treatment standards, and to provide for the resolution of any medical disputes that may arise;

(d) provides for cooperative efforts by the worker, the employer, the rehabilitation providers, and the managed care organization to promote an early return to work for the injured worker;

(e) provides a timely and accurate method of reporting to the department necessary information regarding medical and health care service cost and utilization to enable the department to determine the effectiveness of the plan;

(f) authorizes workers to receive medical treatment from a primary care physician who is not a member of the managed care organization but who maintains the worker's medical records and with whom the worker has a documented history of treatment, if that primary care physician agrees to refer the worker to the managed care organization for any specialized treatment, including physical therapy, that the worker may require and if that primary care physician agrees to comply with all the rules, terms, and conditions regarding services performed by the managed care organization. As used in this subsection (4)(f), "primary care physician" means a physician

who is qualified to be a treating physician and who is a family practitioner, a general practitioner, an internal medicine practitioner, or a chiropractor.

(g) complies with any other requirements determined by department rule to be necessary to provide quality medical services and health care to injured workers.

(5) The department shall refuse to certify or may revoke or suspend the certification of a health care provider, a group of medical service providers, or an entity with a managed care organization to provide managed care if the department finds that:

(a) the plan for providing medical care services fails to meet the requirements of this section; and

(b) service under the plan is not being provided in accordance with the terms of a certified plan."

Section 29. Section 39-71-2401, MCA, is amended to read:

"39-71-2401. Disputes -- jurisdiction -- settlement requirements -- mediation. (1) A dispute concerning benefits arising under this chapter ~~or chapter 72~~, other than the disputes described in subsection (2), must be brought before a department mediator as provided in this part. If a dispute still exists after the parties satisfy the mediation requirements in this part, either party may petition the workers' compensation court for a resolution.

(2) A dispute arising under this chapter that does not concern benefits or a dispute for which a specific provision of this chapter gives the department jurisdiction must be brought before the department.

(3) An appeal from a department order may be made to the workers' compensation court.

(4) Except as otherwise provided in this chapter, before a party may bring a dispute concerning benefits before a mediator, the parties shall attempt to settle as follows:

(a) The party making a demand shall present the other party with a specific written demand that contains sufficient explanation and documentary evidence to enable the other party to thoroughly evaluate the demand.

(b) The party receiving the demand shall respond in writing within 15 working days of receipt. If the demand is denied in whole or in part, the response shall state the basis of the denial.

(c) Upon motion of a party or upon the mediator's own motion, the mediator has the authority to dismiss a petition if he finds that either party did not comply with this subsection. A decision dismissing a petition under this subsection must be in writing and must state in detail the grounds for dismissal. The mediator's decision may be reviewed by the workers' compensation court upon motion of a party.

(d) Nothing in this subsection relieves a party of an obligation otherwise contained in this chapter."

Section 30. Section 39-71-2406, MCA, is amended to read:

"39-71-2406. Purpose. The purpose of this part is to prevent when possible the filing in the workers' compensation court of actions by claimants or insurers relating to claims under ~~chapter 71 or 72 of~~ this ~~title~~ chapter if an equitable and reasonable resolution of the dispute may be effected at an earlier stage. To achieve this purpose, this part provides for a procedure for mandatory, nonbinding mediation. It is the intent of this part that the mediation process be used to resolve cases on an informal basis at minimal cost to the parties, and to this end, the parties are required to fully present their cases at the mediation level. However, if a cause proceeds to the workers' compensation court, the parties are not precluded from presenting additional evidence before the court. If a new issue is raised at the workers' compensation court that was not raised at mediation, the court shall remand the issue to the mediator for consideration."

Section 31. Section 39-71-2408, MCA, is amended to read:

"39-71-2408. Mandatory, nonbinding mediation. (1) Except as otherwise provided, in a dispute arising under ~~chapter 71 or 72 of~~ this ~~title~~ chapter, the insurer and claimant shall mediate any issue concerning benefits and the mediator shall issue a report following the mediation process recommending a solution to the dispute before either party may file a petition in the workers' compensation court.

(2) The resolution recommended by the mediator is without administrative or judicial authority and is not binding on the parties."

Section 32. Section 39-71-2411, MCA, is amended to read:

"39-71-2411. Mediation procedure. (1) Except as otherwise provided, a claimant or an insurer having a dispute relating to benefits under ~~chapter 71 or 72 of~~ this ~~title~~ chapter may petition the department for mediation of the dispute.

(2) A party may take part in mediation proceedings with or without representation.

(3) The mediator shall review the department file for the case and may receive any additional documentation or argument either party submits.

(4) The mediator shall request that each party offer argument summarizing the party's position. A party's argument must fully present the party's case. The argument is not limited by the rules of evidence.

(5) After the parties have presented all their information and argument to the mediator, the mediator shall recommend a solution to the parties within a reasonable time to be established by rule.

(6) A party shall notify the mediator within 25 days of the mailing of the mediator's report whether the

party accepts the mediator's recommendation. If either party does not accept the mediator's recommendation, the party may petition the workers' compensation court for resolution of the dispute.

(7) (a) If a mediator determines that either party failed to cooperate in the mediation process, the mediator shall prepare a written report setting forth the determination and the grounds for the determination. The report must be mailed to the parties and to the workers' compensation court. Unless a party disputes the determination as set forth in subsection (7)(c), the parties shall repeat the mediation process, but only one time.

(b) A mediator may determine that a party has failed to cooperate in the mediation process only if the party failed to:

(i) supply information or offer a summary of the party's position as reasonably requested by the mediator;

(ii) attend scheduled mediation conferences unless excused by the mediator; or

(iii) listen to and review the information and position offered by the opposing party.

(c) If a party disputes a mediator's determination that the party failed to cooperate in the mediation process, the party may file a petition with the workers' compensation court. Upon receipt of a petition, the court shall summon the parties and the mediator to determine by oral discussion whether the mediator's determination of noncooperation is supportable. If the court finds that the mediator's determination is supportable, the court may order the parties to attempt a second time to mediate their dispute."

Section 33. Section 39-73-104, MCA, is amended to read:

"39-73-104. Eligibility requirements for benefits. Payment ~~shall~~ must be made under this chapter to any person who:

(1) has silicosis, as defined in 39-73-101, ~~which~~ that results in ~~his~~ the person's total disability so as to render it impossible for ~~him~~ the person to follow continuously any substantially gainful occupation;

(2) has resided in and been an inhabitant of the state of Montana for 10 years or more immediately preceding the date of the application;

(3) is not receiving, with respect to any month for which ~~he~~ the person would receive a payment under this chapter, compensation under ~~The Occupational Disease Act of Montana, as provided by chapter 72 of this title~~ [section 4], which will equal the sum of $200."

Section 34. Section 39-73-107, MCA, is amended to read:

"39-73-107. Amount of payments. Subject to the provisions of this chapter and the deductions provided in this chapter, any person who has silicosis and who has, subject to the regulations and standards of the

department of labor and industry, been determined by the department to be entitled payment under this chapter for silicosis must be granted a payment by the department of $250 a month, subject to any additional appropriations. If the person is receiving payments under ~~the Occupational Disease Act of Montana, as provided by chapter 72 of this title,~~ [section 4] that are less in the aggregate than $200, then the person is entitled to a payment under this chapter of the difference between the amount received under ~~the Occupational Disease Act of Montana, as provided by chapter 72 of this title~~ [section 4]~~,~~ and $250 a month. The legislature shall authorize additional appropriations that may be necessary to make the increased monthly payments provided in this section."

Section 35. Section 45-6-301, MCA, is amended to read:

"45-6-301. Theft. (1) A person commits the offense of theft when the person purposely or knowingly obtains or exerts unauthorized control over property of the owner and:

(a) has the purpose of depriving the owner of the property;

(b) purposely or knowingly uses, conceals, or abandons the property in a manner that deprives the owner of the property; or

(c) uses, conceals, or abandons the property knowing that the use, concealment, or abandonment probably will deprive the owner of the property.

(2) A person commits the offense of theft when the person purposely or knowingly obtains by threat or deception control over property of the owner and:

(a) has the purpose of depriving the owner of the property;

(b) purposely or knowingly uses, conceals, or abandons the property in a manner that deprives the owner of the property; or

(c) uses, conceals, or abandons the property knowing that the use, concealment, or abandonment probably will deprive the owner of the property.

(3) A person commits the offense of theft when the person purposely or knowingly obtains control over stolen property knowing the property to have been stolen by another and:

(a) has the purpose of depriving the owner of the property;

(b) purposely or knowingly uses, conceals, or abandons the property in a manner that deprives the owner of the property; or

(c) uses, conceals, or abandons the property knowing that the use, concealment, or abandonment probably will deprive the owner of the property.

(4) A person commits the offense of theft when the person purposely or knowingly obtains or exerts unauthorized control over any part of any public assistance provided under Title 52 or 53 by a state or county agency, regardless of the original source of assistance, by means of:

(a) a knowingly false statement, representation, or impersonation; or

(b) a fraudulent scheme or device.

(5) A person commits the offense of theft when the person purposely or knowingly obtains or exerts or helps another obtain or exert unauthorized control over any part of any benefits provided under Title 39, chapter 71 ~~or 72~~, by means of:

(a) a knowingly false statement, representation, or impersonation; or

(b) deception or other fraudulent action.

(6) (a) A person commits the offense of theft when the person purposely or knowingly commits insurance fraud as provided in 33-1-1202 or 33-1-1302; or

(b) purposely or knowingly diverts or misappropriates insurance premiums as provided in 33-17-1102.

(7) A person commits the offense of theft of property by embezzlement when, with the purpose to deprive the owner of the property, the person:

(a) purposely or knowingly obtains or exerts unauthorized control over property of the person's employer or over property entrusted to the person; or

(b) purposely or knowingly obtains by deception control over property of the person's employer or over property entrusted to the person.

(8) (a) A person convicted of the offense of theft of property not exceeding $1,000 in value shall be fined an amount not to exceed $1,000 or be imprisoned in the county jail for a term not to exceed 6 months, or both. A person convicted of a second offense shall be fined $1,000 or be imprisoned in the county jail for a term not to exceed 6 months, or both. A person convicted of a third or subsequent offense shall be fined $1,000 and be imprisoned in the county jail for a term of not less than 30 days or more than 6 months.

(b) Except as provided in subsection (8)(c), a person convicted of the offense of theft of property exceeding $1,000 in value or theft of any commonly domesticated hoofed animal shall be fined an amount not to exceed $50,000 or be imprisoned in a state prison for a term not to exceed 10 years, or both.

(c) A person convicted of the offense of theft of property exceeding $10,000 in value by embezzlement shall be imprisoned in a state prison for a term of not less than 1 year or more than 10 years and may be fined an amount not to exceed $50,000. The court may, in its discretion, place the person on probation with the requirement that restitution be made under terms set by the court. If the terms are not met, the required prison

term may be ordered.

(9) Amounts involved in thefts committed pursuant to a common scheme or the same transaction, whether from the same person or several persons, may be aggregated in determining the value of the property."

Section 36. Section 71-3-1118, MCA, is amended to read:

"71-3-1118. Applicability. (1) Except as provided in subsection (2), this part does not apply to compensation awarded to workers for injury, disease, or death pursuant to the Workers' Compensation Act ~~or the Occupational Disease Act of Montana~~.

(2) This part applies to all payments awarded for medical, therapy, chiropractic, dentistry, counseling, and hospital services pursuant to the acts referred to in subsection (1).

(3) This part does not apply to any benefits payable under:

(a) a policy of life insurance or group life insurance;

(b) a contract of disability insurance, except benefits payable in reimbursement for services rendered by a physician, nurse, physical therapist, occupational therapist, chiropractor, dentist, psychologist, licensed social worker, licensed professional counselor, hospital, or ambulatory surgical facility; or

(c) an annuity contract or to pension benefits payable under a qualified pension plan."

Section 37. Section 85-5-101, MCA, is amended to read:

"85-5-101. Appointment of water commissioners. (1) Whenever the rights of persons to use the waters of any stream, ditch or extension of ditch, watercourse, spring, lake, reservoir, or other source of supply have been determined by a decree of a court of competent jurisdiction, including temporary preliminary, preliminary, and final decrees issued by a water judge, it is the duty of the judge of the district court having jurisdiction of the subject matter, upon the application of the owners of at least 15% of the water rights affected by the decree, in the exercise of the judge's discretion, to appoint one or more commissioners. The commissioners have authority to admeasure and distribute to the parties owning water rights in the source affected by the decree the waters to which they are entitled, according to their rights as fixed by the decree and by any certificates and permits issued under chapter 2 of this title. When petitioners make proper showing that they are not able to obtain the application of the owners of at least 15% of the water rights affected and they are unable to obtain the water to which they are entitled, the judge of the district court having jurisdiction may appoint a water commissioner.

(2) When the existing rights of all appropriators from a source or in an area have been determined in a

temporary preliminary decree, preliminary decree, or final decree issued under chapter 2 of this title, the judge of the district court may, upon application by both the department of natural resources and conservation and one or more holders of valid water rights in the source, appoint a water commissioner. The water commissioner shall distribute to the appropriators, from the source or in the area, the water to which they are entitled.

(3) The department of natural resources and conservation or any person or corporation operating under contract with the department or any other owner of stored waters may petition the court to have stored waters distributed by the water commissioners appointed by the district court. The court may order the commissioner or commissioners appointed by the court to distribute stored water when and as released to water users entitled to the use of the water.

(4) At the time of the appointment of a water commissioner or commissioners, the district court shall fix their compensation, require a commissioner or commissioners to purchase a workers' compensation insurance policy and elect coverage on themselves, and require the owners and users of the distributed waters, including permittees and certificate holders, to pay their proportionate share of fees and compensation, including the cost of workers' compensation insurance purchased by a water commissioner or commissioners. The judge may include the department in the apportionment of costs if it applied for the appointment of a water commissioner under subsection (2).

(5) Upon the application of the board or boards of one or more irrigation districts entitled to the use of water stored in a reservoir that is turned into the natural channel of any stream and withdrawn or diverted at a point downstream for beneficial use, the district court of the judicial district where the most irrigable acres of the irrigation district or districts are situated may appoint a water commissioner to equitably admeasure and distribute stored water to the irrigation district or districts from the channel of the stream into which it has been turned. A commissioner appointed under this subsection has the powers of any commissioner appointed under this chapter, limited only by the purposes of this subsection. A commissioner's compensation is set by the appointing judge and paid by each district and other users of stored water affected by the admeasurement and distribution of the stored water. In all other matters the provisions of this chapter apply so long as they are consistent with this subsection.

(6) A water commissioner appointed by a district court is not an employee of the judicial branch, a local government, or a water user.

(7) A water commissioner who fails to obtain workers' compensation insurance coverage required by subsection (4) is precluded from receiving benefits under Title 39, chapter 71 ~~or 72~~, as a result of the performance of duties as a water commissioner."

NEW SECTION. **Section 38. Repealer.** Sections 39-72-101, 39-72-102, 39-72-103, 39-72-201, 39-72-202, 39-72-203, 39-72-204, 39-72-206, 39-72-301, 39-72-302, 39-72-303, 39-72-305, 39-72-310, 39-72-401, 39-72-402, 39-72-403, 39-72-404, 39-72-405, 39-72-408, 39-72-509, 39-72-601, 39-72-602, 39-72-606, 39-72-607, 39-72-608, 39-72-701, 39-72-703, 39-72-704, 39-72-705, 39-72-706, 39-72-707, 39-72-708, 39-72-709, 39-72-711, 39-72-712, and 39-72-714, MCA, are repealed.

NEW SECTION. **Section 39. Codification instruction.** (1) [Section 1] is intended to be codified as an integral part of Title 39, chapter 71, part 1, and the provisions of Title 39, chapter 71, part 1, apply to [section 1].

(2) [Sections 2 through 5] are intended to be codified as an integral part of Title 39, chapter 71, part 7, and the provisions of Title 39, chapter 71, part 7, apply to [sections 2 through 5].

NEW SECTION. **Section 40. Severability.** If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. **Section 41. Effective date -- applicability.** [This act] is effective July 1, 2005, and applies to occupational diseases that occur on or after July 1, 2005.

- END -

SENATE BILL NO. 481

INTRODUCED BY COCCHIARELLA

A BILL FOR AN ACT ENTITLED: "AN ACT MERGING OCCUPATIONAL DISEASES INTO THE WORKERS' COMPENSATION ACT; ESTABLISHING LEGISLATIVE INTENT TOWARD OCCUPATIONAL DISEASES AS PUBLIC POLICY; DEFINING "OCCUPATIONAL DISEASE"; PROVIDING FOR THE LIABILITY OF INSURERS AND COMPENSATION FOR OCCUPATIONAL DISEASES UNDER THE WORKERS' COMPENSATION ACT; PROVIDING FOR TIME FOR CLAIMS TO BE PRESENTED; AMENDING SECTIONS 2-15-2015, 30-9A-109, 37-1-131, 39-71-105, 39-71-106, 39-71-107, 39-71-116, 39-71-201, 39-71-206, 39-71-211, 39-71-315, 39-71-316, 39-71-317, 39-71-403, 39-71-407, 39-71-416, 39-71-525, 39-71-601, 39-71-603, 39-71-612, 39-71-743, 39-71-915, 39-71-1105, 39-71-2401, 39-71-2406, 39-71-2408, 39-71-2411, 39-73-104, 39-73-107, 45-6-301, 71-3-1118, AND 85-5-101, MCA; REPEALING SECTIONS 39-72-101, 39-72-102, 39-72-103, 39-72-201, 39-72-202, 39-72-203, 39-72-204, 39-72-206, 39-72-301, 39-72-302, 39-72-303, 39-72-305, 39-72-310, 39-72-401, 39-72-402, 39-72-403, 39-72-404, 39-72-405, 39-72-408, 39-72-509, 39-72-601, 39-72-602, 39-72-606, 39-72-607, 39-72-608, 39-72-701, 39-72-703, 39-72-704, 39-72-705, 39-72-706, 39-72-707, 39-72-708, 39-72-709, 39-72-711, 39-72-712, AND 39-72-714, MCA; AND PROVIDING AN EFFECTIVE DATE AND AN APPLICABILITY DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1. Applicability of workers' compensation act -- exceptions.** Except as provided in 39-71-407, 39-71-601, and 39-71-603, this chapter applies to injuries and occupational diseases.

NEW SECTION. **Section 2. Compensation for occupational diseases and medical benefits -- diminution of compensation.** (1) Compensation for occupational diseases must be equal to the compensation and medical benefits provided for injuries in this chapter.

(2) ~~For an occupational disease, compensation payable to the claimant, the claimant's beneficiaries, or the claimant's dependents must be diminished by the amount of any compensation paid or to be paid to the claimant or the claimant's beneficiaries or dependents for the same condition for which benefits are received or may be claimed for an injury~~ WHEN THE SAME MEDICAL CONDITION MAY BE CLAIMED AS AN INJURY AND AN OCCUPATIONAL DISEASE, COMPENSATION PAYABLE TO THE CLAIMANT, THE CLAIMANT'S BENEFICIARIES, OR THE CLAIMANT'S

DEPENDENTS MAY NOT BE DUPLICATED FOR THE SAME CONDITIONS OVER THE SAME TIME PERIOD.

NEW SECTION. **Section 3. Autopsy.** Upon the filing of a claim for compensation for death caused by an occupational disease, if an autopsy is necessary to determine the cause of death, an autopsy may be requested by an insurer. The autopsy must be made under the supervision of the county coroner or a medical examiner. The expense of the autopsy must be paid by the insurer.

NEW SECTION. **Section 4. Benefits for pneumoconiosis.** (1) Pneumoconiosis is an occupational disease that is compensable under this part. However, any benefits granted a claimant under this chapter for pneumoconiosis must be reduced, but not below zero, by an amount equal to the benefits granted the claimant under any program under federal law that pays benefits for a claimant suffering disability from pneumoconiosis.

(2) "Pneumoconiosis" means a chronic dust disease of the lungs arising out of employment in coal mines and includes anthracosis, coal workers' pneumoconiosis, silicosis, or anthracosilicosis arising out of employment.

NEW SECTION. **Section 5. Prohibiting supplementing of benefits.** A person receiving compensation or benefits under chapter 73 of this title is not entitled to compensation or benefits under this chapter.

Section 6. Section 2-15-2015, MCA, is amended to read:

"2-15-2015. Workers' compensation fraud investigation and prosecution office. There is a workers' compensation fraud investigation and prosecution office in the department of justice. The office shall investigate and prosecute cases referred by the state compensation insurance fund or the department of labor and industry on behalf of the uninsured employers' fund. The office is under the supervision and control of the attorney general and consists of:

(1) one or more investigators qualified by education, training, experience, and high professional competence in investigative procedures who shall investigate violations of the provisions of Title 39, ~~chapters~~ chapter 71 ~~and 72~~, at the request of the state compensation insurance fund or the department of labor and industry on behalf of the uninsured employers' fund; and

(2) one or more attorneys licensed to practice law in Montana who shall prosecute violations of the provisions of Title 39, ~~chapters~~ chapter 71 ~~and 72~~. The attorneys may also assist county attorneys in prosecuting violations of Title 39, ~~chapters~~ chapter 71 ~~and 72~~, without charge to the county.

(3) The state compensation insurance fund, the department of labor and industry, and the department

of justice shall submit to the legislature for approval one proposed biennial budget for the workers' compensation fraud office. The proposed budget for staffing and related expenses must be based upon the needs of the state compensation insurance fund and the department of labor and industry on behalf of the uninsured employers' fund for investigating and prosecuting workers' compensation fraud."

Section 7. Section 30-9A-109, MCA, is amended to read:

"30-9A-109. Scope. (1) Except as otherwise provided in subsections (3) and (4), this chapter applies to:

(a) any transaction, regardless of its form, that creates a security interest in personal property or fixtures by contract;

(b) an agricultural lien;

(c) a sale of an account, chattel paper, payment intangible, or promissory note;

(d) a consignment;

(e) a security interest arising under 30-2-401, 30-2-505, 30-2-711(3), or 30-2A-508(5), to the extent provided in 30-9A-110; and

(f) a security interest arising under 30-4-208 or 30-5-118.

(2) The application of this chapter to a security interest in a secured obligation is not affected by the fact that the obligation is itself secured by a transaction or interest to which this chapter does not apply.

(3) This chapter does not apply to the extent that:

(a) a statute, regulation, or treaty of the United States preempts this chapter;

(b) another statute of this state expressly governs the creation, perfection, priority, or enforcement of a security interest created by this state or a governmental unit of this state;

(c) a statute of another state, a foreign country, or a governmental unit of another state or a foreign country, other than a statute generally applicable to security interests, expressly governs creation, perfection, priority, or enforcement of a security interest created by the state, country, or governmental unit; or

(d) the rights of a transferee beneficiary or nominated person under a letter of credit are independent and superior under 30-5-134.

(4) This chapter does not apply to:

(a) a landlord's lien, other than an agricultural lien;

(b) a lien, other than an agricultural lien, given by statute or other rule of law for services or materials, but 30-9A-333 applies with respect to priority of the lien;

(c) an assignment of a claim for wages, salary, or other compensation of an employee;

(d) a sale of accounts, chattel paper, payment intangibles, or promissory notes as part of a sale of the business out of which they arose;

(e) an assignment of accounts, chattel paper, payment intangibles, or promissory notes that is for the purpose of collection only;

(f) an assignment of a right to payment under a contract to an assignee that is also obliged to perform under the contract;

(g) an assignment of a single account, payment intangible, or promissory note to an assignee in full or partial satisfaction of a preexisting indebtedness;

(h) a transfer of an interest in or an assignment of a claim under a policy of insurance, other than an assignment by or to a health care provider of a health-care-insurance receivable and any subsequent assignment of the right to payment, but 30-9A-315 and 30-9A-322 apply with respect to proceeds and priorities in proceeds;

(i) an assignment of a right represented by a judgment, other than a judgment taken on a right to payment that was collateral;

(j) a right of recoupment or setoff, but:

(i) 30-9A-340 applies with respect to the effectiveness of rights of recoupment or setoff against deposit accounts; and

(ii) 30-9A-404 applies with respect to defenses or claims of an account debtor;

(k) the creation or transfer of an interest in or lien on real property, including a lease or rents under the interest in real property, except to the extent that provision is made for:

(i) liens on real property in 30-9A-203 and 30-9A-308;

(ii) fixtures in 30-9A-334;

(iii) fixture filings in 30-9A-501, 30-9A-502, 30-9A-512, 30-9A-516, and 30-9A-519; and

(iv) security agreements covering personal and real property in 30-9A-604;

(l) an assignment of a claim arising in tort, other than a commercial tort claim, but 30-9A-315 and 30-9A-322 apply with respect to proceeds and priorities in proceeds;

(m) a transfer by a government or governmental subdivision or agency;

(n) an assignment of a deposit account in a consumer transaction, except that 30-9A-315 and 30-9A-322 apply with respect to proceeds and priorities in proceeds; or

(o) an assignment of payments made to or on behalf of claimants pursuant to Title 39, chapter 51, 71, ~~72,~~ or 73."

Section 8. Section 37-1-131, MCA, is amended to read:

"37-1-131. Duties of boards -- quorum required. Each board within the department shall:

(1) set and enforce standards and rules governing the licensing, certification, registration, and conduct of the members of the particular profession or occupation within its jurisdiction;

(2) sit in judgment in hearings for the suspension, revocation, or denial of a license of an actual or potential member of the particular profession or occupation within its jurisdiction. The hearings must be conducted by a hearing examiner when required under 37-1-121(1).

(3) suspend, revoke, or deny a license of a person who the board determines, after a hearing as provided in subsection (2), is guilty of knowingly defrauding, abusing, or aiding in the defrauding or abusing of the workers' compensation system in violation of the provisions of Title 39, chapter 71 ~~or 72~~;

(4) pay to the department its pro rata share of the assessed costs of the department under 37-1-101(6);

(5) consult with the department before the board initiates a program expansion, under existing legislation, to determine if the board has adequate money and appropriation authority to fully pay all costs associated with the proposed program expansion. The board may not expand a program if the board does not have adequate money and appropriation authority available.

(6) A board, board panel, or subcommittee convened to conduct board business must have a majority of its members, which constitutes a quorum, present to conduct business."

Section 9. Section 39-71-105, MCA, is amended to read:

"39-71-105. Declaration of public policy. For the purposes of interpreting and applying Title 39, ~~chapters~~ chapter 71 ~~and 72~~, the following is the public policy of this state:

(1) It is an objective of the Montana workers' compensation system to provide, without regard to fault, wage supplement and medical benefits to a worker suffering from a work-related injury or disease. Wage-loss benefits are not intended to make an injured worker whole; they are intended to assist a worker at a reasonable cost to the employer. Within that limitation, the wage-loss benefit should bear a reasonable relationship to actual wages lost as a result of a work-related injury or disease.

(2) A worker's removal from the work force due to a work-related injury or disease has a negative impact on the worker, the worker's family, the employer, and the general public. Therefore, it is an objective of the workers' compensation system to return a worker to work as soon as possible after the worker has suffered a work-related injury or disease.

(3) Montana's workers' compensation and occupational disease insurance systems are intended to be

primarily self-administering. Claimants should be able to speedily obtain benefits, and employers should be able to provide coverage at reasonably constant rates. To meet these objectives, the system must be designed to minimize reliance upon lawyers and the courts to obtain benefits and interpret liabilities.

(4) Title 39, ~~chapters~~ chapter 71 ~~and 72~~, must be construed according to ~~their~~ its terms and not liberally in favor of any party.

(5) It is the intent of the legislature that:

(a) stress claims, often referred to as "mental-mental claims" and "mental-physical claims", are not compensable under Montana's workers' compensation and occupational disease laws. The legislature recognizes that these claims are difficult to objectively verify and that the claims have a potential to place an economic burden on the workers' compensation and occupational disease system. The legislature also recognizes that there are other states that do not provide compensation for various categories of stress claims and that stress claims have presented economic problems for certain other jurisdictions. In addition, not all injuries are compensable under the present system, as is the case with repetitive injury claims, and it is within the legislature's authority to define the limits of the workers' compensation and occupational disease system.

(b) for occupational disease claims, because of the nature of exposure, workers should not be required to provide notice to employers of the disease as required of injuries and that the requirements for filing of claims reflect consideration of when the worker knew or should have known ~~of exposure to~~ THAT THE WORKER'S CONDITION RESULTED FROM an occupational disease. The legislature recognizes that occupational diseases in the workplace are caused by events occurring on more than a single day or work shift and that it is within the legislature's authority to define an occupational disease and establish the causal connection to the workplace."

Section 10. Section 39-71-106, MCA, is amended to read:

"39-71-106. No liability for reporting violation. A person, including but not limited to an insurer or an employer, may not be held liable for civil damages as a result of reporting in good faith information that the person believes proves a violation of the provisions of ~~chapter 72 or~~ this chapter."

Section 11. Section 39-71-107, MCA, is amended to read:

"39-71-107. Insurers to act promptly on claims -- in-state adjusters. (1) Pursuant to the public policy stated in 39-71-105, prompt claims handling practices are necessary to provide appropriate service to injured workers, to employers, and to providers who are the customers of the workers' compensation system.

(2) All workers' compensation and occupational disease claims filed pursuant to the Workers'

Compensation Act ~~and the Occupational Disease Act of Montana~~ must be adjusted by a person in Montana. For a claim to be considered as adjusted by a person in Montana, the person adjusting the claim is required to determine the entitlement to benefits, authorize payment of all benefits due, manage the claim, have authority to settle the claim, maintain an office located in Montana, and adjust Montana claims from that office. Use of a mailbox or maildrop in Montana does not constitute maintaining an office in Montana.

(3) An insurer shall maintain the documents related to each claim filed with the insurer under the Workers' Compensation Act ~~and the Occupational Disease Act of Montana~~ at the Montana office of the person adjusting the claim in Montana until the claim is settled. The documents may be either original documents or duplicates of the original documents and must be maintained in a manner that allows the documents to be retrieved from that office and copied at the request of the claimant or the department. Settled claim files stored outside of the adjuster's office must be made available within 48 hours of a request for the file. Electronic or optically imaged documents are permitted.

(4) An insurer shall provide to the claimant:

(a) a written statement of the reasons that a claim is being denied at the time of denial;

(b) whenever benefits requested by a claimant are denied, a written explanation of how the claimant may appeal an insurer's decision; and

(c) a written explanation of the amount of wage loss benefits being paid to the claimant, along with an explanation of the calculation used to compute those benefits. The explanation must be sent within 7 days of the initial payment of the benefit.

(5) An insurer shall:

(a) begin making payments that are due on a claim within 14 days of acceptance of the claim, unless the insurer promptly notifies the claimant that the insurer needs additional information in order to begin paying benefits and specifies the information needed; and

(b) pay settlements within 30 days of the date the department issues an order approving the settlement.

(6) An insurer may not make payments pursuant to 39-71-608 or any other reservation of rights for more than 90 days without:

(a) written consent of the claimant; or

(b) approval of the department.

(7) The department may adopt rules to implement this section.

(8) (a) For purposes of this section, "settled claim" means a department-approved or court-ordered compromise of benefits between a claimant and an insurer or a claim that was paid in full.

(b) The term does not include a claim in which there has been only a lump-sum advance of benefits."

Section 12. Section 39-71-116, MCA, is amended to read:

"39-71-116. Definitions. Unless the context otherwise requires, in this chapter, the following definitions apply:

(1) "Actual wage loss" means that the wages that a worker earns or is qualified to earn after the worker reaches maximum healing are less than the actual wages the worker received at the time of the injury.

(2) "Administer and pay" includes all actions by the state fund under the Workers' Compensation Act ~~and the Occupational Disease Act of Montana~~ necessary to:

(a) investigation, review, and settlement of claims;

(b) payment of benefits;

(c) setting of reserves;

(d) furnishing of services and facilities; and

(e) use of actuarial, audit, accounting, vocational rehabilitation, and legal services.

(3) "Aid or sustenance" means a public or private subsidy made to provide a means of support, maintenance, or subsistence for the recipient.

(4) "Average weekly wage" means the mean weekly earnings of all employees under covered employment, as defined and established annually by the department. It is established at the nearest whole dollar number and must be adopted by the department before July 1 of each year.

(5) "Beneficiary" means:

(a) a surviving spouse living with or legally entitled to be supported by the deceased at the time of injury;

(b) an unmarried child under 18 years of age;

(c) an unmarried child under 22 years of age who is a full-time student in an accredited school or is enrolled in an accredited apprenticeship program;

(d) an invalid child over 18 years of age who is dependent, as defined in 26 U.S.C. 152, upon the decedent for support at the time of injury;

(e) a parent who is dependent, as defined in 26 U.S.C. 152, upon the decedent for support at the time of the injury if a beneficiary, as defined in subsections (5)(a) through (5)(d), does not exist; and

(f) a brother or sister under 18 years of age if dependent, as defined in 26 U.S.C. 152, upon the decedent for support at the time of the injury but only until the age of 18 years and only when a beneficiary, as defined in subsections (5)(a) through (5)(e), does not exist.

(6) "Business partner" means the community, governmental entity, or business organization that provides the premises for work-based learning activities for students.

(7) "Casual employment" means employment not in the usual course of the trade, business, profession, or occupation of the employer.

(8) "Child" includes a posthumous child, a dependent stepchild, and a child legally adopted prior to the injury.

(9) "Construction industry" means the major group of general contractors and operative builders, heavy construction (other than building construction) contractors, and special trade contractors listed in major group 23 in the North American Industry Classification System Manual. The term does not include office workers, design professionals, salespersons, estimators, or any other related employment that is not directly involved on a regular basis in the provision of physical labor at a construction or renovation site.

(10) "Days" means calendar days, unless otherwise specified.

(11) "Department" means the department of labor and industry.

(12) "Fiscal year" means the period of time between July 1 and the succeeding June 30.

(13) "Household or domestic employment" means employment of persons other than members of the household for the purpose of tending to the aid and comfort of the employer or members of the employer's family, including but not limited to housecleaning and yard work, but does not include employment beyond the scope of normal household or domestic duties, such as home health care or domiciliary care.

(14) "Insurer" means an employer bound by compensation plan No. 1, an insurance company transacting business under compensation plan No. 2, or the state fund under compensation plan No. 3.

(15) "Invalid" means one who is physically or mentally incapacitated.

(16) "Limited liability company" is as defined in 35-8-102.

(17) "Maintenance care" means treatment designed to provide the optimum state of health while minimizing recurrence of the clinical status.

(18) "Medical stability", "maximum healing", or "maximum medical healing" means a point in the healing process when further material improvement would not be reasonably expected from primary medical treatment.

(19) "Objective medical findings" means medical evidence, including range of motion, atrophy, muscle strength, muscle spasm, or other diagnostic evidence, substantiated by clinical findings.

(20) (a) "Occupational disease" means harm, damage, or death arising out of or contracted in the course and scope of employment caused by events occurring on more than a single day or work shift.

(b) The term does not include a physical or mental condition arising from emotional or mental stress or

from a nonphysical stimulus or activity.

~~(20)~~(21) "Order" means any decision, rule, direction, requirement, or standard of the department or any other determination arrived at or decision made by the department.

~~(21)~~(22) "Palliative care" means treatment designed to reduce or ease symptoms without curing the underlying cause of the symptoms.

~~(22)~~(23) "Payroll", "annual payroll", or "annual payroll for the preceding year" means the average annual payroll of the employer for the preceding calendar year or, if the employer has not operated a sufficient or any length of time during the calendar year, 12 times the average monthly payroll for the current year. However, an estimate may be made by the department for any employer starting in business if average payrolls are not available. This estimate must be adjusted by additional payment by the employer or refund by the department, as the case may actually be, on December 31 of the current year. An employer's payroll must be computed by calculating all wages, as defined in 39-71-123, that are paid by an employer.

~~(23)~~(24) "Permanent partial disability" means a physical condition in which a worker, after reaching maximum medical healing:

(a) has a permanent impairment established by objective medical findings;

(b) is able to return to work in some capacity but the permanent impairment impairs the worker's ability to work; and

(c) has an actual wage loss as a result of the injury.

~~(24)~~(25) "Permanent total disability" means a physical condition resulting from injury as defined in this chapter, after a worker reaches maximum medical healing, in which a worker does not have a reasonable prospect of physically performing regular employment. Regular employment means work on a recurring basis performed for remuneration in a trade, business, profession, or other occupation in this state. Lack of immediate job openings is not a factor to be considered in determining if a worker is permanently totally disabled.

~~(25)~~(26) The "plant of the employer" includes the place of business of a third person while the employer has access to or control over the place of business for the purpose of carrying on the employer's usual trade, business, or occupation.

~~(26)~~(27) "Primary medical services" means treatment prescribed by a treating physician, for conditions resulting from the injury, necessary for achieving medical stability.

~~(27)~~(28) "Public corporation" means the state or a county, municipal corporation, school district, city, city under a commission form of government or special charter, town, or village.

~~(28)~~(29) "Reasonably safe place to work" means that the place of employment has been made as free

from danger to the life or safety of the employee as the nature of the employment will reasonably permit.

~~(29)~~(30) "Reasonably safe tools and appliances" are tools and appliances that are adapted to and that are reasonably safe for use for the particular purpose for which they are furnished.

~~(30)~~(31) (a) "Secondary medical services" means those medical services or appliances that are considered not medically necessary for medical stability. The services and appliances include but are not limited to spas or hot tubs, work hardening, physical restoration programs and other restoration programs designed to address disability and not impairment, or equipment offered by individuals, clinics, groups, hospitals, or rehabilitation facilities.

(b) (i) As used in this subsection ~~(30)~~ (31), "disability" means a condition in which a worker's ability to engage in gainful employment is diminished as a result of physical restrictions resulting from an injury. The restrictions may be combined with factors, such as the worker's age, education, work history, and other factors that affect the worker's ability to engage in gainful employment.

(ii) Disability does not mean a purely medical condition.

~~(31)~~(32) "Sole proprietor" means the person who has the exclusive legal right or title to or ownership of a business enterprise.

~~(32)~~(33) "Temporary partial disability" means a physical condition resulting from an injury, as defined in 39-71-119, in which a worker, prior to maximum healing:

(a) is temporarily unable to return to the position held at the time of injury because of a medically determined physical restriction;

(b) returns to work in a modified or alternative employment; and

(c) suffers a partial wage loss.

~~(33)~~(34) "Temporary service contractor" means a person, firm, association, partnership, limited liability company, or corporation conducting business that hires its own employees and assigns them to clients to fill a work assignment with a finite ending date to support or supplement the client's workforce in situations resulting from employee absences, skill shortages, seasonal workloads, and special assignments and projects.

~~(34)~~(35) "Temporary total disability" means a physical condition resulting from an injury, as defined in this chapter, that results in total loss of wages and exists until the injured worker reaches maximum medical healing.

~~(35)~~(36) "Temporary worker" means a worker whose services are furnished to another on a part-time or temporary basis to fill a work assignment with a finite ending date to support or supplement a workforce in situations resulting from employee absences, skill shortages, seasonal workloads, and special assignments and projects.

~~(36)~~(37) "Treating physician" means a person who is primarily responsible for the treatment of a worker's compensable injury and is:

(a) a physician licensed by the state of Montana under Title 37, chapter 3, and has admitting privileges to practice in one or more hospitals, if any, in the area where the physician is located;

(b) a chiropractor licensed by the state of Montana under Title 37, chapter 12;

(c) a physician assistant-certified licensed by the state of Montana under Title 37, chapter 20, if there is not a treating physician, as provided for in subsection ~~(36)(a)~~ (37)(a), in the area where the physician assistant-certified is located;

(d) an osteopath licensed by the state of Montana under Title 37, chapter 3;

(e) a dentist licensed by the state of Montana under Title 37, chapter 4;

(f) for a claimant residing out of state or upon approval of the insurer, a treating physician defined in subsections ~~(36)(a)~~ (37)(a) through ~~(36)(e)~~ (37)(e) who is licensed or certified in another state; or

(g) an advanced practice registered nurse licensed by the state of Montana under Title 37, chapter 8, recognized by the board of nursing as a nurse practitioner or a clinical nurse specialist, and practicing in consultation with a physician licensed under Title 37, chapter 3, if there is not a treating physician, as provided for in subsection ~~(36)(a)~~ (37)(a), in the area in which the advanced practice registered nurse is located.

~~(37)~~(38) "Work-based learning activities" means job training and work experience conducted on the premises of a business partner as a component of school-based learning activities authorized by an elementary, secondary, or postsecondary educational institution.

~~(38)~~(39) "Year", unless otherwise specified, means calendar year."

Section 13. Section 39-71-201, MCA, is amended to read:

"39-71-201. Administration fund. (1) A workers' compensation administration fund is established out of which all costs of administering the Workers' Compensation ~~and Occupational Disease Acts~~ Act and the statutory occupational safety acts that the department is required to administer, with the exception of the subsequent injury fund, as provided for in 39-71-907, and the uninsured employers' fund, are to be paid upon lawful appropriation. The department shall collect and deposit in the state treasury to the credit of the workers' compensation administration fund:

(a) all fees and penalties provided in 39-71-205, 39-71-223, 39-71-304, 39-71-307, 39-71-308, 39-71-315, 39-71-316, 39-71-401(6), 39-71-2204, 39-71-2205, and 39-71-2337; and

(b) all fees paid by an assessment of 3% of paid losses, plus administrative fines and interest provided

by this section.

(2) For the purposes of this section, paid losses include the following benefits paid during the preceding calendar year for injuries covered by the Workers' Compensation Act ~~and the Occupational Disease Act of Montana~~ without regard to the application of any deductible whether the employer or the insurer pays the losses:

(a) total compensation benefits paid; and

(b) except for medical benefits in excess of $200,000 for each occurrence that are exempt from assessment, total medical benefits paid for medical treatment rendered to an injured worker, including hospital treatment and prescription drugs.

(3) Each plan No. 1 employer, plan No. 2 insurer subject to the provisions of this section, and plan No. 3, the state fund, shall file annually on March 1 in the form and containing the information required by the department a report of paid losses pursuant to subsection (2).

(4) Each employer enrolled under compensation plan No. 1, compensation plan No. 2, or compensation plan No. 3, the state fund, shall pay a proportionate share of all costs of administering and regulating the Workers' Compensation Act ~~and the Occupational Disease Act of Montana~~ and the statutory occupational safety acts that the department is required to administer, with the exception of the subsequent injury fund, as provided for in 39-71-907, and the uninsured employers' fund. In addition, compensation plan No. 3, the state fund, shall pay a proportionate share of these costs based upon paid losses for claims arising before July 1, 1990.

(5) (a) Each employer enrolled under compensation plan No. 1 shall pay an assessment to fund administrative and regulatory costs. The assessment is equal to 3% of the paid losses paid in the preceding calendar year by or on behalf of the plan No. 1 employer or $500, whichever is greater. Any entity, other than the department, that assumes the obligations of an employer enrolled under compensation plan No. 1 is considered to be the employer for the purposes of this section.

(b) An employer formerly enrolled under compensation plan No. 1 shall pay an assessment to fund administrative and regulatory costs. The assessment is equal to 3% of the paid losses paid in the preceding calendar year by or on behalf of the employer for claims arising out of the time when the employer was enrolled under compensation plan No. 1.

(c) Payment of the assessment provided for by this subsection (5) must be paid by the employer in:

(i) one installment due on July 1; or

(ii) two equal installments due on July 1 and December 31 of each year.

(d) If an employer fails to timely pay to the department the assessment under this section, the department may impose on the employer an administrative fine of $500 plus interest on the delinquent amount

at the annual interest rate of 12%. Administrative fines and interest must be deposited in the workers' compensation administration fund.

(6) (a) Compensation plan No. 3, the state fund, shall pay an assessment to fund administrative and regulatory costs attributable to claims arising before July 1, 1990. The assessment is equal to 3% of the paid losses paid in the preceding calendar year for claims arising before July 1, 1990. As required by 39-71-2352, the state fund may not pass along to insured employers the cost of the assessment for administrative and regulatory costs that is attributable to claims arising before July 1, 1990.

(b) Payment of the assessment must be paid in:

(i) one installment due on July 1; or

(ii) two equal installments due on July 1 and December 31 of each year.

(c) If the state fund fails to timely pay to the department the assessment under this section, the department may impose on the state fund an administrative fine of $500 plus interest on the delinquent amount at the annual interest rate of 12%. Administrative fines and interest must be deposited in the workers' compensation administration fund.

(7) (a) Each employer insured under compensation plan No. 2 or plan No. 3, the state fund, shall pay a premium surcharge to fund administrative and regulatory costs. The premium surcharge must be collected by each plan No. 2 insurer and by plan No. 3, the state fund, from each employer that it insures. The premium surcharge must be stated as a separate cost on an insured employer's policy or on a separate document submitted to the insured employer and must be identified as "workers' compensation regulatory assessment surcharge". The premium surcharge must be excluded from the definition of premiums for all purposes, including computation of insurance producers' commissions or premium taxes. However, an insurer may cancel a workers' compensation policy for nonpayment of the premium surcharge. When collected, assessments may not constitute an element of loss for the purpose of establishing rates for workers' compensation insurance but, for the purpose of collection, must be treated as a separate cost imposed upon insured employers.

(b) The amount to be funded by the premium surcharge is equal to 3% of the paid losses paid in the preceding calendar year by or on behalf of all plan No. 2 insurers and 3% of paid losses for claims arising on or after July 1, 1990, for plan No. 3, the state fund, plus or minus any adjustments as provided by subsection (7)(f). The amount to be funded must be divided by the total premium paid by all employers enrolled under compensation plan No. 2 or plan No. 3 during the preceding calendar year. A single premium surcharge rate, applicable to all employers enrolled in compensation plan No. 2 or plan No. 3, must be calculated annually by the department by not later than April 30. The resulting rate, expressed as a percentage, is levied against the

premium paid by each employer enrolled under compensation plan No. 2 or plan No. 3 in the next fiscal year.

(c) On or before April 30, 2001, and on each succeeding April 30, the department, in consultation with the advisory organization designated pursuant to 33-16-1023, shall notify plan No. 2 insurers and plan No. 3, the state fund, of the premium surcharge percentage to be effective for policies written or renewed annually on and after July 1 of that year.

(d) The premium surcharge must be paid whenever the employer pays a premium to the insurer. Each insurer shall collect the premium surcharge levied against every employer that it insures. Each insurer shall pay to the department all money collected as a premium surcharge within 20 days of the end of the calendar quarter in which the money was collected. If an insurer fails to timely pay to the department the premium surcharge collected under this section, the department may impose on the insurer an administrative fine of $500 plus interest on the delinquent amount at the annual interest rate of 12%. Administrative fines and interest must be deposited in the workers' compensation administration fund.

(e) If an employer fails to remit to an insurer the total amount due for the premium and premium surcharge, the amount received by the insurer must be applied to the premium surcharge first and the remaining amount applied to the premium due.

(f) The amount actually collected as a premium surcharge in a given year must be compared to the 3% of paid losses paid in the preceding year. Any amount collected in excess of the 3% must be deducted from the amount to be collected as a premium surcharge in the following year. The amount collected that is less than the 3% must be added to the amount to be collected as a premium surcharge in the following year.

(8) On or before April 30~~, 2001, and on~~ of each ~~succeeding April 30~~ year, upon a determination by the department, an insurer under compensation plan No. 2 that pays benefits in the preceding calendar year but that will not collect any premium for coverage in the following fiscal year shall pay an assessment equal to 3% of paid losses paid in the preceding calendar year, subject to a minimum assessment of $500, that is due on July 1.

(9) An employer that makes a first-time application for permission to enroll under compensation plan No. 1 shall pay an assessment of $500 within 15 days of being granted permission by the department to enroll under compensation plan No. 1.

(10) The department shall deposit all funds received pursuant to this section in the state treasury, as provided in this section.

(11) The administration fund must be debited with expenses incurred by the department in the general administration of the provisions of this chapter, including the salaries of its members, officers, and employees and the travel expenses of the members, officers, and employees, as provided for in 2-18-501 through 2-18-503,

incurred while on the business of the department either within or without the state.

(12) Disbursements from the administration money must be made after being approved by the department upon claim for disbursement.

(13) The department may assess and collect the workers' compensation regulatory assessment surcharge from uninsured employers, as defined in 39-71-501, that fail to properly comply with the coverage requirements of the Workers' Compensation Act ~~and the Occupational Disease Act of Montana~~. Any amounts collected by the department pursuant to this subsection must be deposited in the workers' compensation administration fund."

Section 14. Section 39-71-206, MCA, is amended to read:

"39-71-206. Legal advisers of department and state fund -- investigative and prosecution services. (1) The attorney general is the legal adviser of the department and the state fund and shall represent either entity in all proceedings if requested by the department or state fund. The department and state fund may employ other attorneys or legal advisers as they consider necessary.

(2) As provided in 2-15-2015, the attorney general shall provide investigative and prosecution services to the state fund with respect to violations of ~~Title 39, chapters~~ this chapter ~~71 and 72~~."

Section 15. Section 39-71-211, MCA, is amended to read:

"39-71-211. Fraud detection and prevention unit -- expenditure accounting. (1) The state fund shall establish a fraud prevention and detection unit. The unit is responsible for developing detection and prevention procedures, providing detection services, and providing training in the prevention and detection of fraudulent conduct under Title 39, ~~chapters~~ chapter 71 ~~and 72~~, that is subject to prosecution under Title 45. The unit shall refer all cases of suspected fraudulent conduct to the workers' compensation fraud investigation and prosecution office established in 2-15-2015.

(2) The state fund shall expend money to investigate fraud pursuant to this section and shall separately account for money expended."

Section 16. Section 39-71-315, MCA, is amended to read:

"39-71-315. Prohibited actions -- penalty. (1) The following actions by a medical provider constitute violations and are subject to the penalty in subsection (2):

(a) failing to document, under oath, the provision of the services or treatment for which compensation

is claimed under ~~chapter 72 or~~ this chapter; or

(b) referring a worker for treatment or diagnosis of an injury or illness that is compensable under ~~chapter 72 or~~ this chapter to a facility owned wholly or in part by the provider, unless the provider informs the worker of the ownership interest and provides the name and address of alternate facilities, if any exist.

(2) A person who violates this section may be assessed a penalty of not less than $200 or more than $500 for each offense. The department shall assess and collect the penalty. Penalties collected pursuant to this section must be paid into the state general fund. The workers' compensation court has jurisdiction over actions brought to collect the penalty and over disputes concerning the penalty assessment. Disputes brought pursuant to this section are not subject to mediation.

(3) Subsection (1)(b) does not apply to medical services provided to an injured worker by a treating physician with an ownership interest in a managed care organization that has been certified by the department."

Section 17. Section 39-71-316, MCA, is amended to read:

"39-71-316. Filing true claim -- obtaining benefits through deception or other fraudulent means. (1) A person filing a claim under ~~chapter 72 or~~ this chapter, by signing the claim, affirms the information filed is true and correct to the best of that person's knowledge.

(2) (a) A person who obtains or assists in obtaining benefits to which the person is not entitled or who obtains or assists another person in obtaining benefits to which the other person is not entitled under ~~chapter 72 or~~ this chapter is guilty of theft and may be prosecuted under 45-6-301. A county attorney or the attorney general may initiate criminal proceedings against the person. This subsection includes but is not limited to a person who is receiving temporary total disability benefits, permanent total disability benefits, or rehabilitation benefits while working without the knowledge and concurrence of the insurer.

(b) As used in subsection (2)(a), "person" includes but is not limited to an employee, employer, insurer, or medical service provider.

(3) (a) The department may require a person convicted of theft under 45-6-301(5) to pay to the department an amount equal to 10 times the amount paid by an insurer on the false claim, provided that the amount does not exceed $50,000. If upon demand of the department the person refuses to pay the fine, the department may petition the workers' compensation court to collect the money owed.

(b) The department shall:

(i) use the money collected pursuant to subsection (3)(a) to administer and enforce the provisions of this section; and

(ii) forward any surplus money to the department of justice. The forwarded money must be used exclusively for the staffing and operation of the workers' compensation fraud investigation and prosecution office established in 2-15-2015.

(c) This section does not limit an insurer's civil remedies to collect for money paid to a person convicted under 45-6-301(5).

(4) A person licensed under the provisions of Title 37 is subject to suspension, revocation, or denial of a license if the person knowingly claims or assists in the claiming of benefits in violation of the provisions of ~~chapter 72 or~~ this chapter."

Section 18. Section 39-71-317, MCA, is amended to read:

"39-71-317. Employer not to terminate worker for filing claim -- preference -- jurisdiction over dispute. (1) An employer may not use as grounds for terminating a worker the filing of a claim under ~~chapter 72 or~~ this chapter. The district court has exclusive jurisdiction over disputes concerning the grounds for termination under this section.

(2) When an injured worker is capable of returning to work within 2 years from the date of injury and has received a medical release to return to work, the worker must be given a preference over other applicants for a comparable position that becomes vacant if the position is consistent with the worker's physical condition and vocational abilities.

(3) This preference applies only to employment with the employer for whom the employee was working at the time the injury occurred.

(4) The workers' compensation court has exclusive jurisdiction to administer or resolve a dispute concerning the reemployment preference under this section. A dispute concerning the reemployment preference is not subject to mediation or a contested case hearing."

Section 19. Section 39-71-403, MCA, is amended to read:

"39-71-403. Plan three exclusive for state agencies -- election of plan by public corporations -- financing of self-insurance fund -- exemption for university system -- definition. (1) Except as provided in subsection (5), if a state agency is the employer, the terms, conditions, and provisions of compensation plan No. 3, state fund, are exclusive, compulsory, and obligatory upon both employer and employee. Any sums necessary to be paid under the provisions of this chapter by a state agency are considered to be ordinary and necessary expenses of the agency. The agency shall ~~make appropriation of and~~ pay the sums into the state fund at the time

and in the manner provided for in this chapter, notwithstanding that the state agency may have failed to anticipate the ordinary and necessary expense in a budget, estimate of expenses, appropriations, ordinances, or otherwise.

(2) A public corporation, other than a state agency, may elect coverage under compensation plan No. 1, plan No. 2, or plan No. 3, separately or jointly with any other public corporation, other than a state agency. A public corporation electing compensation plan No. 1 may purchase reinsurance or issue bonds or notes pursuant to subsection (3)(b). A public corporation electing compensation plan No. 1 is subject to the same provisions as a private employer electing compensation plan No. 1.

(3) (a) A public corporation, other than a state agency, that elects plan No. 1 may establish a fund sufficient to pay the compensation and benefits provided for in ~~chapter 72 and~~ this chapter and to discharge all liabilities that are reasonably incurred during the fiscal year for which the election is effective. Proceeds from the fund must be used only to pay claims covered by ~~chapter 72 and~~ this chapter and for actual and necessary expenses required for the efficient administration of the fund, including debt service on any bonds and notes issued pursuant to subsection (3)(b).

(b) (i) A public corporation, other than a state agency, separately or jointly with another public corporation, other than a state agency, may issue and sell its bonds and notes for the purpose of establishing, in whole or in part, the self-insurance workers' compensation fund provided for in subsection (3)(a) and to pay the costs associated with the sale and issuance of the bonds. Bonds and notes may be issued in an amount not exceeding 0.18% of the total assessed value of taxable property, determined as provided in 15-8-111, of the public corporation as of the date of issue. The bonds and notes must be authorized by resolution of the governing body of the public corporation and are payable from an annual property tax levied in the amount necessary to pay principal and interest on the bonds or notes. This authority to levy an annual property tax exists despite any provision of law or maximum levy limitation, including 15-10-420, to the contrary. The revenue derived from the sale of the bonds and notes may not be used for any other purpose.

(ii) The bonds and notes:

(A) may be sold at public or private sale;

(B) do not constitute debt within the meaning of any statutory debt limitation; and

(C) may contain other terms and provisions that the governing body determines.

(iii) Two or more public corporations, other than state agencies, may agree to exercise their respective borrowing powers jointly under this subsection (3)(b) or may authorize a joint board to exercise the powers on their behalf.

(iv) The fund established from the proceeds of bonds and notes issued and sold under this subsection

(3)(b) may, if sufficient, be used in lieu of a surety bond, reinsurance, specific and aggregate excess insurance, or any other form of additional security necessary to demonstrate the public corporation's ability to discharge all liabilities as provided in subsection (3)(a). Subject to the total assessed value limitation in subsection (3)(b)(i), a public corporation may issue bonds and notes to establish a fund sufficient to discharge liabilities for periods greater than 1 year.

(4) All money in the fund established under subsection (3)(a) not needed to meet immediate expenditures must be invested by the governing body of the public corporation or the joint board created by two or more public corporations as provided in subsection (3)(b)(iii), and all proceeds of the investment must be credited to the fund.

(5) The provisions of subsection (1) do not apply to the Montana university system.

(6) As used in subsections (2) through (4), "public corporation" includes the Montana university system."

Section 20. Section 39-71-407, MCA, is amended to read:

"39-71-407. Liability of insurers -- limitations. (1) ~~Each~~ For workers' compensation injuries, each insurer is liable for the payment of compensation, in the manner and to the extent provided in this section, to an employee of an employer covered under plan No. 1, plan No. 2, and the state fund under plan No. 3 that it insures who receives an injury arising out of and in the course of employment or, in the case of death from the injury, to the employee's beneficiaries, if any.

(2) (a) An insurer is liable for an injury, as defined in 39-71-119, if the injury is established by objective medical findings and if the claimant establishes that it is more probable than not that:

(i) a claimed injury has occurred; or

(ii) a claimed injury aggravated a preexisting condition.

(b) Proof that it was medically possible that a claimed injury occurred or that the claimed injury aggravated a preexisting condition is not sufficient to establish liability.

(3) (a) An employee who suffers an injury or dies while traveling is not covered by this chapter unless:

(i) the employer furnishes the transportation or the employee receives reimbursement from the employer for costs of travel, gas, oil, or lodging as a part of the employee's benefits or employment agreement and the travel is necessitated by and on behalf of the employer as an integral part or condition of the employment; or

(ii) the travel is required by the employer as part of the employee's job duties.

(b) A payment made to an employee under a collective bargaining agreement, personnel policy manual, or employee handbook or any other document provided to the employee that is not wages but is designated as

an incentive to work at a particular jobsite is not a reimbursement for the costs of travel, gas, oil, or lodging, and the employee is not covered under this chapter while traveling.

(4) An employee is not eligible for benefits otherwise payable under this chapter if the employee's use of alcohol or drugs not prescribed by a physician is the major contributing cause of the accident. However, if the employer had knowledge of and failed to attempt to stop the employee's use of alcohol or drugs, this subsection does not apply.

(5) If a claimant who has reached maximum healing suffers a subsequent nonwork-related injury to the same part of the body, the workers' compensation insurer is not liable for any compensation or medical benefits caused by the subsequent nonwork-related injury.

(6) An employee is not eligible for benefits payable under this chapter unless the entitlement to benefits is established by objective medical findings that contain sufficient factual and historical information concerning the relationship of the worker's condition to the original injury.

(7) For occupational diseases, every employer enrolled under plan No. 1, every insurer under plan No. 2, or the state fund under plan No. 3 is liable for the payment of compensation, in the manner and to the extent provided in this chapter, to an employee of an employer covered under plan No. 1, plan No. 2, or the state fund under plan No. 3 with an occupational disease that arises out of or is contracted in the course and scope of employment.

(8) Occupational diseases are considered to arise out of employment or be contracted in the course and scope of employment if:

(a) the occupational disease is established by objective medical findings; and

(b) the events occurring on more than a single day or work shift are more than 50% responsible for the occupational disease in relation to other factors contributing to the occupational disease.

(9) When compensation is payable for an occupational disease, the only employer liable is the employer in whose employment the employee was last injuriously exposed to the hazard of the disease.

(10) When there is more than one insurer and only one employer at the time that the employee was injuriously exposed to the hazard of the disease, the liability rests with the insurer providing coverage at the earlier of:

(a) the time that the occupational disease was first diagnosed by a treating physician or medical panel; or

(b) the time that the employee knew or should have known that the condition was the result of an occupational disease.

(11) In the case of pneumoconiosis, any coal mine operator who has acquired a mine in the state or substantially all of the assets of a mine from a person who was an operator of the mine on or after December 30, 1969, is liable for and shall secure the payment of all benefits that would have been payable by that person with respect to miners previously employed in the mine if acquisition had not occurred and that person had continued to operate the mine, and the prior operator of the mine is not relieved of any liability under this section.

~~(7)~~(12) As used in this section, "major contributing cause" means a cause that is the leading cause contributing to the result when compared to all other contributing causes."

Section 21. Section 39-71-416, MCA, is amended to read:

"39-71-416. Benefit reduction for third-party recovery. (1) If an employee is injured or dies and obtains a third-party recovery, settlement, or award, an insurer may reduce by 30% the benefits paid or that are required to be paid to the employee or beneficiary pursuant to this chapter ~~71 or 72~~ as a result of the injury or death. The reduction applies to any recovery, settlement, or award regardless of the form of action or the nature of damages. The total of any reductions may not exceed 30% of any third-party recovery, settlement, or award.

(2) This section does not limit or prohibit an insurer's right to pursue subrogation pursuant to 39-71-414.

(3) If an insurer is entitled to subrogation pursuant to 39-71-414, the amount subrogated must be offset by any reduction in benefits pursuant to subsection (1)."

Section 22. Section 39-71-525, MCA, is amended to read:

"39-71-525. Confidentiality of records -- exception for use by public employees. Information obtained from any individual under this part is confidential and may not be disclosed, sold, or opened to public inspection except to department employees when necessary to allow them to perform their public duties under Title 39, ~~chapters~~ chapter 71 ~~and 72~~, or to provide relevant and necessary information to other public entities or pursuant to a subpoena issued upon a showing of compelling state interest."

Section 23. Section 39-71-601, MCA, is amended to read:

"39-71-601. Statute of limitation on presentment of claim -- waiver. (1) ~~In case of personal injury or death~~ Except for a claim for benefits for occupational diseases pursuant to subsections (3) and (4), all claims in the case of personal injury or death must be forever barred unless signed by the claimant or the claimant's representative and presented in writing to the employer, the insurer, or the department, as the case may be, within 12 months from the date of the happening of the accident, either by the claimant or someone legally

authorized to act on the claimant's behalf.

(2) The insurer may waive the time requirement up to an additional 24 months upon a reasonable showing by the claimant of:

(a) lack of knowledge of disability;

(b) latent injury; or

(c) equitable estoppel.

(3) When a claimant seeks benefits for an occupational disease, the claimant's claims for benefits must be presented in writing to the employer, the employer's insurer, or the department within 1 year from the date that the claimant knew or should have known that the claimant's condition resulted from an occupational disease. When a beneficiary seeks benefits under this chapter, claims for death benefits must be presented in writing to the employer, the employer's insurer, or the department within 1 year from the date that the beneficiary knew or should have known that the decedent's death was related to an occupational disease.

~~(3)~~(4) Any dispute regarding the statute of limitations for filing time is considered a dispute that, after mediation pursuant to department rules, is subject to jurisdiction of the workers' compensation court."

Section 24. Section 39-71-603, MCA, is amended to read:

"39-71-603. Notice of injuries other than death to be submitted within thirty days -- exception. (1) A claim to recover benefits under the Workers' Compensation Act for injuries not resulting in death may not be considered compensable unless, within 30 days after the occurrence of the accident that is claimed to have caused the injury, notice of the time and place where the accident occurred and the nature of the injury is given to the employer or the employer's insurer by the injured employee or someone on the employee's behalf. Actual knowledge of the accident and injury on the part of the employer or the employer's managing agent or superintendent in charge of the work in which the injured employee was engaged at the time of the injury is equivalent to notice.

(2) If a sole proprietor, partner, manager of a manager-managed limited liability company, member of a member-managed limited liability company, or corporate officer covered under this chapter is injured in an accident, the sole proprietor, partner, manager, member, or corporate officer or an appointed designee shall, within 30 days, notify the insurer of the time and location of the accident and the nature of the injury.

(3) This section does not apply to occupational diseases."

Section 25. Section 39-71-612, MCA, is amended to read:

"39-71-612. Costs and attorney fees that may be assessed against insurer by workers' compensation judge -- barring of attorney fees under common fund or other doctrines. (1) If an insurer pays or submits a written offer of payment of compensation under this chapter ~~71 or 72 of this title~~ but controversy relates to the amount of compensation due, the case is brought before the workers' compensation judge for adjudication of the controversy, and the award granted by the judge is greater than the amount paid or offered by the insurer, reasonable attorney fees and costs as established by the workers' compensation judge if the case has gone to a hearing may be awarded by the judge in addition to the amount of compensation.

(2) An award of attorney fees under subsection (1) may be made only if it is determined that the actions of the insurer were unreasonable. Any written offer of payment made 30 days or more before the date of hearing must be considered a valid offer of payment for the purposes of this section.

(3) A finding of unreasonableness against an insurer made under this section does not constitute a finding that the insurer acted in bad faith or violated the unfair trade practices provisions of Title 33, chapter 18.

(4) Attorney fees may be awarded only under the provisions of subsections (1) and (2) and may not be awarded under the common fund doctrine or any other action or doctrine in law or equity."

Section 26. Section 39-71-743, MCA, is amended to read:

"39-71-743. Assignment or attachment of payments. (1) Payments under this chapter may not be assignable, subject to attachment or garnishment, or held liable in any way for debts, except:

(a) as provided in 71-3-1118;

(b) a portion of any lump-sum award or periodic payment to pay a monetary obligation for current or past-due child support, subject to the limitations in subsection (2), whenever the support obligation is established by order of a court of competent jurisdiction or by order rendered in an administrative process authorized by state law; or

(c) as provided in 53-2-612 or 53-2-613 for medical benefits paid pursuant to ~~chapter 71 or 72 of~~ this ~~title~~ chapter.

(2) Payments under this chapter are subject to assignment, attachment, or garnishment for child support as follows:

(a) for any periodic payment, an amount up to the percentage amount established in the guidelines promulgated by the department of public health and human services pursuant to 40-5-209; or

(b) for any lump-sum award, an amount up to that portion of the award that is approved for payment on the basis of a past-due child support obligation.

(3) After determination that the claim is covered under the Workers' Compensation Act ~~or Occupational Disease Act of Montana~~, the liability for payment of the claim is the responsibility of the appropriate workers' compensation insurer. Except as provided in 39-71-704(7), a fee or charge is not payable by the injured worker for treatment of injuries sustained if liability is accepted by the insurer."

Section 27. Section 39-71-915, MCA, is amended to read:

"39-71-915. Assessment of insurer -- employers -- definition -- collection. (1) As used in this section, "paid losses" means the following benefits paid during the preceding calendar year for injuries covered by the ~~Montana~~ Workers' Compensation Act ~~and the Occupational Disease Act of Montana~~ without regard to the application of any deductible, regardless of whether the employer or the insurer pays the losses:

(a) total compensation benefits paid; and

(b) except for medical benefits in excess of $200,000 for each occurrence that are exempt from assessment, total medical benefits paid for medical treatment rendered to an injured worker, including hospital treatment and prescription drugs.

(2) The fund must be maintained by assessing each plan No. 1 employer, each employer insured by a plan No. 2 insurer, plan No. 3, the state fund, with respect to claims arising before July 1, 1990, and each employer insured by plan No. 3, the state fund. The assessment amount is the total amount of paid losses reimbursed from the fund in the preceding calendar year and the expenses of administration less other income. The total assessment amount to be collected must be allocated among plan No. 1 employers, plan No. 2 employers, plan No. 3, the state fund, and plan No. 3 employers, based on a proportionate share of paid losses for the calendar year preceding the year in which the assessment is collected. The board of investments shall invest the money of the fund, and the investment income must be deposited in the fund.

(3) On or before May 31 each year, the department shall notify each plan No. 1 employer, plan No. 2 insurer, and plan No. 3, the state fund, of the amount to be assessed for the ensuing fiscal year. The amount to be assessed against the state fund must separately identify the amount attributed to claims arising before July 1, 1990, and the amount attributable to state fund claims arising on or after July 1, 1990. On or before April 30 each year, the department, in consultation with the advisory organization designated under 33-16-1023, shall notify plan No. 2 insurers and plan No. 3 of the premium surcharge rate to be effective for policies written or renewed on and after July 1 in that year.

(4) The portion of the plan No. 1 assessment assessed against an individual plan No. 1 employer is a proportionate amount of total plan No. 1 paid losses during the preceding calendar year that is equal to the

percentage that the total paid losses of the individual plan No. 1 employer bore to the total paid losses of all plan No. 1 employers during the preceding calendar year.

(5) The portion of the assessment attributable to state fund claims arising before July 1, 1990, is the proportionate amount that is equal to the percentage that total paid losses for those claims during the preceding calendar year bore to the total paid losses for all plans in the preceding calendar year. As required by 39-71-2352, the state fund may not pass along to insured employers the cost of the subsequent injury fund assessment that is attributable to claims arising before July 1, 1990.

(6) The remaining portion of the assessment must be paid by way of a surcharge on premiums paid by employers being insured by a plan No. 2 insurer or plan No. 3, the state fund, for policies written or renewed annually on or after July 1. The surcharge rate must be computed by dividing the remaining portion of the assessment by the total amount of premiums paid by employers insured under plan No. 2 or plan No. 3 in the previous calendar year. The numerator for the calculation must be adjusted as provided by subsection (9).

(7) Each plan No. 2 insurer providing workers' compensation insurance and plan No. 3, the state fund, shall collect from its policyholders the assessment premium surcharge provided for in subsection (6). When collected, the assessment premium surcharge may not constitute an element of loss for the purpose of establishing rates for workers' compensation insurance but, for the purpose of collection, must be treated as separate costs imposed upon insured employers. The total of this assessment premium surcharge must be stated as a separate cost on an insured employer's policy or on a separate document submitted by the insured employer and must be identified as "workers' compensation subsequent injury fund surcharge". Each assessment premium surcharge must be shown as a percentage of the total workers' compensation policyholder premium. This assessment premium surcharge must be collected at the same time and in the same manner that the premium for the coverage is collected. The assessment premium surcharge must be excluded from the definition of premiums for all purposes, including computation of insurance producers' commissions or premium taxes, except that an insurer may cancel a workers' compensation policy for nonpayment of the assessment premium surcharge. Cancellation must be in accordance with the procedures applicable to the nonpayment of premium. If an employer fails to remit to an insurer the total amount due for the premium and assessment premium surcharge, the amount received by the insurer must be applied to the assessment premium surcharge first and the remaining amount applied to the premium due.

(8) (a) All assessments paid to the department must be deposited in the fund.

(b) Each plan No. 1 employer shall pay its assessment by July 1.

(c) Each plan No. 2 insurer and plan No. 3, the state fund, shall remit to the department all assessment

premium surcharges collected during a calendar quarter by not later than 20 days following the end of the quarter.

(d) The state fund shall pay the portion of the assessment attributable to claims arising before July 1, 1990, by July 1.

(e) If a plan No. 1 employer, a plan No. 2 insurer, or plan No. 3, the state fund, fails to timely pay to the department the assessment or assessment premium surcharge under this section, the department may impose on the plan No. 1 employer, the plan No. 2 insurer, or plan No. 3, the state fund, an administrative fine of $100 plus interest on the delinquent amount at the annual interest rate of 12%. Administrative fines and interest must be deposited in the fund.

(9) The amount of the assessment premium surcharge actually collected pursuant to subsection (7) must be compared each year to the amount assessed and upon which the premium surcharge was calculated. The amount undercollected or overcollected in any given year must be used as an adjustment to the numerator provided for by subsection (6) for the following year's assessment premium surcharge."

Section 28. Section 39-71-1105, MCA, is amended to read:

"39-71-1105. Managed care organizations -- application -- certification. (1) A health care provider, a group of medical service providers, or an entity with a managed care organization may make written application to the department to become certified under this section to provide managed care to ~~injured~~ workers for injuries or occupational diseases that are covered under this chapter ~~or for occupational diseases that are covered under the Occupational Disease Act of Montana~~. However, this section does not authorize an organization that is formed, owned, or operated by a workers' compensation insurer or self-insured employer other than a health care provider to become certified to provide managed care. When a health care provider, a group of medical service providers, or an entity with a managed care organization is establishing a managed care organization and independent physical therapy practices exist in the community, the managed care organization is encouraged to utilize independent physical therapists as part of the managed care organization if the independent physical therapists agree to abide by all the applicable requirements for a managed care organization set forth in this section, in rules established by the department, and in the provisions of a managed care plan for which certification is being sought.

(2) Each application for certification must be accompanied by an application fee if prescribed by the department. A certificate is valid for the period prescribed by the department, unless it is revoked or suspended at an earlier date.

(3) The department shall establish by rule the form for the application for certification and the required

information regarding the proposed plan for providing medical services. The information includes but is not limited to:

(a) a list of names of each individual who will provide services under the managed care plan, together with appropriate evidence of compliance with any licensing or certification requirements for that individual to practice in the state;

(b) names of the individuals who will be designated as treating physicians and who will be responsible for the coordination of medical services;

(c) a description of the times, places, and manner of providing primary medical services under the plan;

(d) a description of the times, places, and manner of providing secondary medical services, if any, that the applicants wish to provide; and

(e) satisfactory evidence of the ability to comply with any financial requirements to ensure delivery of service in accordance with the plan that the department may require.

(4) The department shall certify a group of medical service providers or an entity with a managed care organization to provide managed care under a plan if the department finds that the plan:

(a) proposes to provide coordination of services that meet quality, continuity, and other treatment standards prescribed by the department and will provide all primary medical services that may be required by this chapter in a manner that is timely and effective for the worker;

(b) provides appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of services;

(c) provides adequate methods of peer review and service utilization review to prevent excessive or inappropriate treatment, to exclude from participation in the plan those individuals who violate these treatment standards, and to provide for the resolution of any medical disputes that may arise;

(d) provides for cooperative efforts by the worker, the employer, the rehabilitation providers, and the managed care organization to promote an early return to work for the injured worker;

(e) provides a timely and accurate method of reporting to the department necessary information regarding medical and health care service cost and utilization to enable the department to determine the effectiveness of the plan;

(f) authorizes workers to receive medical treatment from a primary care physician who is not a member of the managed care organization but who maintains the worker's medical records and with whom the worker has a documented history of treatment, if that primary care physician agrees to refer the worker to the managed care organization for any specialized treatment, including physical therapy, that the worker may require and if that

primary care physician agrees to comply with all the rules, terms, and conditions regarding services performed by the managed care organization. As used in this subsection (4)(f), "primary care physician" means a physician who is qualified to be a treating physician and who is a family practitioner, a general practitioner, an internal medicine practitioner, or a chiropractor.

(g) complies with any other requirements determined by department rule to be necessary to provide quality medical services and health care to injured workers.

(5) The department shall refuse to certify or may revoke or suspend the certification of a health care provider, a group of medical service providers, or an entity with a managed care organization to provide managed care if the department finds that:

(a) the plan for providing medical care services fails to meet the requirements of this section; and

(b) service under the plan is not being provided in accordance with the terms of a certified plan."

Section 29. Section 39-71-2401, MCA, is amended to read:

"39-71-2401. Disputes -- jurisdiction -- settlement requirements -- mediation. (1) A dispute concerning benefits arising under this chapter ~~or chapter 72~~, other than the disputes described in subsection (2), must be brought before a department mediator as provided in this part. If a dispute still exists after the parties satisfy the mediation requirements in this part, either party may petition the workers' compensation court for a resolution.

(2) A dispute arising under this chapter that does not concern benefits or a dispute for which a specific provision of this chapter gives the department jurisdiction must be brought before the department.

(3) An appeal from a department order may be made to the workers' compensation court.

(4) Except as otherwise provided in this chapter, before a party may bring a dispute concerning benefits before a mediator, the parties shall attempt to settle as follows:

(a) The party making a demand shall present the other party with a specific written demand that contains sufficient explanation and documentary evidence to enable the other party to thoroughly evaluate the demand.

(b) The party receiving the demand shall respond in writing within 15 working days of receipt. If the demand is denied in whole or in part, the response shall state the basis of the denial.

(c) Upon motion of a party or upon the mediator's own motion, the mediator has the authority to dismiss a petition if he finds that either party did not comply with this subsection. A decision dismissing a petition under this subsection must be in writing and must state in detail the grounds for dismissal. The mediator's decision may be reviewed by the workers' compensation court upon motion of a party.

(d) Nothing in this subsection relieves a party of an obligation otherwise contained in this chapter."

Section 30. Section 39-71-2406, MCA, is amended to read:

"39-71-2406. Purpose. The purpose of this part is to prevent when possible the filing in the workers' compensation court of actions by claimants or insurers relating to claims under ~~chapter 71 or 72 of~~ this ~~title~~ chapter if an equitable and reasonable resolution of the dispute may be effected at an earlier stage. To achieve this purpose, this part provides for a procedure for mandatory, nonbinding mediation. It is the intent of this part that the mediation process be used to resolve cases on an informal basis at minimal cost to the parties, and to this end, the parties are required to fully present their cases at the mediation level. However, if a cause proceeds to the workers' compensation court, the parties are not precluded from presenting additional evidence before the court. If a new issue is raised at the workers' compensation court that was not raised at mediation, the court shall remand the issue to the mediator for consideration."

Section 31. Section 39-71-2408, MCA, is amended to read:

"39-71-2408. Mandatory, nonbinding mediation. (1) Except as otherwise provided, in a dispute arising under ~~chapter 71 or 72 of~~ this ~~title~~ chapter, the insurer and claimant shall mediate any issue concerning benefits and the mediator shall issue a report following the mediation process recommending a solution to the dispute before either party may file a petition in the workers' compensation court.

(2) The resolution recommended by the mediator is without administrative or judicial authority and is not binding on the parties."

Section 32. Section 39-71-2411, MCA, is amended to read:

"39-71-2411. Mediation procedure. (1) Except as otherwise provided, a claimant or an insurer having a dispute relating to benefits under ~~chapter 71 or 72 of~~ this ~~title~~ chapter may petition the department for mediation of the dispute.

(2) A party may take part in mediation proceedings with or without representation.

(3) The mediator shall review the department file for the case and may receive any additional documentation or argument either party submits.

(4) The mediator shall request that each party offer argument summarizing the party's position. A party's argument must fully present the party's case. The argument is not limited by the rules of evidence.

(5) After the parties have presented all their information and argument to the mediator, the mediator shall

recommend a solution to the parties within a reasonable time to be established by rule.

(6) A party shall notify the mediator within 25 days of the mailing of the mediator's report whether the party accepts the mediator's recommendation. If either party does not accept the mediator's recommendation, the party may petition the workers' compensation court for resolution of the dispute.

(7) (a) If a mediator determines that either party failed to cooperate in the mediation process, the mediator shall prepare a written report setting forth the determination and the grounds for the determination. The report must be mailed to the parties and to the workers' compensation court. Unless a party disputes the determination as set forth in subsection (7)(c), the parties shall repeat the mediation process, but only one time.

(b) A mediator may determine that a party has failed to cooperate in the mediation process only if the party failed to:

(i) supply information or offer a summary of the party's position as reasonably requested by the mediator;

(ii) attend scheduled mediation conferences unless excused by the mediator; or

(iii) listen to and review the information and position offered by the opposing party.

(c) If a party disputes a mediator's determination that the party failed to cooperate in the mediation process, the party may file a petition with the workers' compensation court. Upon receipt of a petition, the court shall summon the parties and the mediator to determine by oral discussion whether the mediator's determination of noncooperation is supportable. If the court finds that the mediator's determination is supportable, the court may order the parties to attempt a second time to mediate their dispute."

Section 33. Section 39-73-104, MCA, is amended to read:

"39-73-104. Eligibility requirements for benefits. Payment ~~shall~~ must be made under this chapter to any person who:

(1) has silicosis, as defined in 39-73-101, ~~which~~ that results in ~~his~~ the person's total disability so as to render it impossible for ~~him~~ the person to follow continuously any substantially gainful occupation;

(2) has resided in and been an inhabitant of the state of Montana for 10 years or more immediately preceding the date of the application;

(3) is not receiving, with respect to any month for which ~~he~~ the person would receive a payment under this chapter, compensation under ~~The Occupational Disease Act of Montana, as provided by chapter 72 of this title~~ [section 4], which will equal the sum of $200."

Section 34. Section 39-73-107, MCA, is amended to read:

"39-73-107. Amount of payments. Subject to the provisions of this chapter and the deductions provided in this chapter, any person who has silicosis and who has, subject to the regulations and standards of the department of labor and industry, been determined by the department to be entitled payment under this chapter for silicosis must be granted a payment by the department of $250 a month, subject to any additional appropriations. If the person is receiving payments under ~~the Occupational Disease Act of Montana, as provided by chapter 72 of this title,~~ [section 4] that are less in the aggregate than $200, then the person is entitled to a payment under this chapter of the difference between the amount received under ~~the Occupational Disease Act of Montana, as provided by chapter 72 of this title~~ [section 4]~~,~~ and $250 a month. The legislature shall authorize additional appropriations that may be necessary to make the increased monthly payments provided in this section."

Section 35. Section 45-6-301, MCA, is amended to read:

"45-6-301. Theft. (1) A person commits the offense of theft when the person purposely or knowingly obtains or exerts unauthorized control over property of the owner and:

(a) has the purpose of depriving the owner of the property;

(b) purposely or knowingly uses, conceals, or abandons the property in a manner that deprives the owner of the property; or

(c) uses, conceals, or abandons the property knowing that the use, concealment, or abandonment probably will deprive the owner of the property.

(2) A person commits the offense of theft when the person purposely or knowingly obtains by threat or deception control over property of the owner and:

(a) has the purpose of depriving the owner of the property;

(b) purposely or knowingly uses, conceals, or abandons the property in a manner that deprives the owner of the property; or

(c) uses, conceals, or abandons the property knowing that the use, concealment, or abandonment probably will deprive the owner of the property.

(3) A person commits the offense of theft when the person purposely or knowingly obtains control over stolen property knowing the property to have been stolen by another and:

(a) has the purpose of depriving the owner of the property;

(b) purposely or knowingly uses, conceals, or abandons the property in a manner that deprives the owner of the property; or

(c) uses, conceals, or abandons the property knowing that the use, concealment, or abandonment probably will deprive the owner of the property.

(4) A person commits the offense of theft when the person purposely or knowingly obtains or exerts unauthorized control over any part of any public assistance provided under Title 52 or 53 by a state or county agency, regardless of the original source of assistance, by means of:

(a) a knowingly false statement, representation, or impersonation; or

(b) a fraudulent scheme or device.

(5) A person commits the offense of theft when the person purposely or knowingly obtains or exerts or helps another obtain or exert unauthorized control over any part of any benefits provided under Title 39, chapter 71 ~~or 72~~, by means of:

(a) a knowingly false statement, representation, or impersonation; or

(b) deception or other fraudulent action.

(6) (a) A person commits the offense of theft when the person purposely or knowingly commits insurance fraud as provided in 33-1-1202 or 33-1-1302; or

(b) purposely or knowingly diverts or misappropriates insurance premiums as provided in 33-17-1102.

(7) A person commits the offense of theft of property by embezzlement when, with the purpose to deprive the owner of the property, the person:

(a) purposely or knowingly obtains or exerts unauthorized control over property of the person's employer or over property entrusted to the person; or

(b) purposely or knowingly obtains by deception control over property of the person's employer or over property entrusted to the person.

(8) (a) A person convicted of the offense of theft of property not exceeding $1,000 in value shall be fined an amount not to exceed $1,000 or be imprisoned in the county jail for a term not to exceed 6 months, or both. A person convicted of a second offense shall be fined $1,000 or be imprisoned in the county jail for a term not to exceed 6 months, or both. A person convicted of a third or subsequent offense shall be fined $1,000 and be imprisoned in the county jail for a term of not less than 30 days or more than 6 months.

(b) Except as provided in subsection (8)(c), a person convicted of the offense of theft of property exceeding $1,000 in value or theft of any commonly domesticated hoofed animal shall be fined an amount not to exceed $50,000 or be imprisoned in a state prison for a term not to exceed 10 years, or both.

(c) A person convicted of the offense of theft of property exceeding $10,000 in value by embezzlement shall be imprisoned in a state prison for a term of not less than 1 year or more than 10 years and may be fined

an amount not to exceed $50,000. The court may, in its discretion, place the person on probation with the requirement that restitution be made under terms set by the court. If the terms are not met, the required prison term may be ordered.

(9) Amounts involved in thefts committed pursuant to a common scheme or the same transaction, whether from the same person or several persons, may be aggregated in determining the value of the property."

Section 36. Section 71-3-1118, MCA, is amended to read:

"71-3-1118. Applicability. (1) Except as provided in subsection (2), this part does not apply to compensation awarded to workers for injury, disease, or death pursuant to the Workers' Compensation Act ~~or the Occupational Disease Act of Montana~~.

(2) This part applies to all payments awarded for medical, therapy, chiropractic, dentistry, counseling, and hospital services pursuant to the acts referred to in subsection (1).

(3) This part does not apply to any benefits payable under:

(a) a policy of life insurance or group life insurance;

(b) a contract of disability insurance, except benefits payable in reimbursement for services rendered by a physician, nurse, physical therapist, occupational therapist, chiropractor, dentist, psychologist, licensed social worker, licensed professional counselor, hospital, or ambulatory surgical facility; or

(c) an annuity contract or to pension benefits payable under a qualified pension plan."

Section 37. Section 85-5-101, MCA, is amended to read:

"85-5-101. Appointment of water commissioners. (1) Whenever the rights of persons to use the waters of any stream, ditch or extension of ditch, watercourse, spring, lake, reservoir, or other source of supply have been determined by a decree of a court of competent jurisdiction, including temporary preliminary, preliminary, and final decrees issued by a water judge, it is the duty of the judge of the district court having jurisdiction of the subject matter, upon the application of the owners of at least 15% of the water rights affected by the decree, in the exercise of the judge's discretion, to appoint one or more commissioners. The commissioners have authority to admeasure and distribute to the parties owning water rights in the source affected by the decree the waters to which they are entitled, according to their rights as fixed by the decree and by any certificates and permits issued under chapter 2 of this title. When petitioners make proper showing that they are not able to obtain the application of the owners of at least 15% of the water rights affected and they are unable to obtain the water to which they are entitled, the judge of the district court having jurisdiction may appoint

a water commissioner.

(2) When the existing rights of all appropriators from a source or in an area have been determined in a temporary preliminary decree, preliminary decree, or final decree issued under chapter 2 of this title, the judge of the district court may, upon application by both the department of natural resources and conservation and one or more holders of valid water rights in the source, appoint a water commissioner. The water commissioner shall distribute to the appropriators, from the source or in the area, the water to which they are entitled.

(3) The department of natural resources and conservation or any person or corporation operating under contract with the department or any other owner of stored waters may petition the court to have stored waters distributed by the water commissioners appointed by the district court. The court may order the commissioner or commissioners appointed by the court to distribute stored water when and as released to water users entitled to the use of the water.

(4) At the time of the appointment of a water commissioner or commissioners, the district court shall fix their compensation, require a commissioner or commissioners to purchase a workers' compensation insurance policy and elect coverage on themselves, and require the owners and users of the distributed waters, including permittees and certificate holders, to pay their proportionate share of fees and compensation, including the cost of workers' compensation insurance purchased by a water commissioner or commissioners. The judge may include the department in the apportionment of costs if it applied for the appointment of a water commissioner under subsection (2).

(5) Upon the application of the board or boards of one or more irrigation districts entitled to the use of water stored in a reservoir that is turned into the natural channel of any stream and withdrawn or diverted at a point downstream for beneficial use, the district court of the judicial district where the most irrigable acres of the irrigation district or districts are situated may appoint a water commissioner to equitably admeasure and distribute stored water to the irrigation district or districts from the channel of the stream into which it has been turned. A commissioner appointed under this subsection has the powers of any commissioner appointed under this chapter, limited only by the purposes of this subsection. A commissioner's compensation is set by the appointing judge and paid by each district and other users of stored water affected by the admeasurement and distribution of the stored water. In all other matters the provisions of this chapter apply so long as they are consistent with this subsection.

(6) A water commissioner appointed by a district court is not an employee of the judicial branch, a local government, or a water user.

(7) A water commissioner who fails to obtain workers' compensation insurance coverage required by

subsection (4) is precluded from receiving benefits under Title 39, chapter 71 ~~or 72~~, as a result of the performance of duties as a water commissioner."

NEW SECTION. **Section 38. Repealer.** Sections 39-72-101, 39-72-102, 39-72-103, 39-72-201, 39-72-202, 39-72-203, 39-72-204, 39-72-206, 39-72-301, 39-72-302, 39-72-303, 39-72-305, 39-72-310, 39-72-401, 39-72-402, 39-72-403, 39-72-404, 39-72-405, 39-72-408, 39-72-509, 39-72-601, 39-72-602, 39-72-606, 39-72-607, 39-72-608, 39-72-701, 39-72-703, 39-72-704, 39-72-705, 39-72-706, 39-72-707, 39-72-708, 39-72-709, 39-72-711, 39-72-712, and 39-72-714, MCA, are repealed.

NEW SECTION. **Section 39. Codification instruction.** (1) [Section 1] is intended to be codified as an integral part of Title 39, chapter 71, part 1, and the provisions of Title 39, chapter 71, part 1, apply to [section 1].

(2) [Sections 2 through 5] are intended to be codified as an integral part of Title 39, chapter 71, part 7, and the provisions of Title 39, chapter 71, part 7, apply to [sections 2 through 5].

NEW SECTION. **SECTION 40. COORDINATION INSTRUCTION.** IF HOUSE BILL NO. 126 IS PASSED AND APPROVED AND IF IT INCLUDES A SECTION THAT REPEALS 39-71-416, THEN [SECTION 21 OF THIS ACT], AMENDING 39-71-416, IS VOID.

NEW SECTION. **Section 41. Severability.** If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. **Section 42. Effective date -- applicability.** [This act] is effective July 1, 2005, and applies to occupational diseases that occur on or after July 1, 2005.

- END -

FISCAL NOTE

Bill #: SB0481 **Title:** Merge occupational diseases into Workers' Compensation Act

Primary Sponsor: Cocchiarella, V **Status:** As Introduced

Sponsor signature Date David Ewer, Budget Director Date

Fiscal Summary

	FY 2006 Difference	FY 2007 Difference
Expenditures:		
General Fund	$0	$0
Revenue:		
General Fund	$0	$0
Net Impact on General Fund Balance:	$0	$0

☐ Significant Local Gov. Impact ☐ Technical Concerns

☐ Included in the Executive Budget ☐ Significant Long-Term Impacts

☐ Dedicated Revenue Form Attached ☐ Needs to be included in HB 2

Fiscal Analysis

ASSUMPTIONS:

Montana State Fund

1. This legislation is intended to merge Occupational Diseases into the Workers' Compensation act to codify recent court decisions.
2. The result of the merging of these acts should not cause fiscal impact, as the fiscal impact of the court decisions has already been included in the State Fund's rate structure.